

January, 1959

MENTAL HYGIENE

*Published Quarterly by the
National Association for Mental Health*

Quarterly Journal of the
National Association for Mental Health, Inc.
George S. Stevenson, M.D., *Editor*
Harriett Scantland Hoptner, *Assistant Editor*

MENTAL HYGIENE

MENTAL HYGIENE aims to bring dependable information to everyone interested in mental problems. Here are original papers by writers of authority, reviews of important books, reports of surveys, special investigations and new methods of prevention and treatment in the broad field of mental hygiene and psychopathology. Our aim is to make MENTAL HYGIENE indispensable to all thoughtful readers. Physicians, lawyers, educators, clergymen, public officials and students of social problems find it of special value.

The National Association for Mental Health does not necessarily endorse or assume responsibility for opinions expressed or statements made in signed articles, nor does the reviewing of a book imply its recommendation by the National Association for Mental Health. Although this magazine is copyrighted, the contents may be freely quoted with appropriate credit.

\$6.00 a year (Canadian \$6.25; foreign \$6.50). Single copy \$1.50.
Publication office: 49 Sheridan Ave., Albany 10, N. Y. Editorial
and business office: 10 Columbus Circle, New York 19, N. Y.
Second class mail privileges authorized at Albany, N. Y.

© 1959 by the National Association for Mental Health, Inc.

Articles

- 3 An experiment in public education THELMA V. OWEN AND
M. G. STEMMERMANN
- 8 Visitors to mental hospitals: A fertile field for research
ROBERT SOMMER
- 16 Socialization and sewing as the means to an end TED O. IRWIN
- 21 A new hypothesis in infant adoptive placements RUTH LATIMER
- 32 Psychiatric examination of the child MARVIN I. SHAPIRO
- 40 Communication between psychotherapist and teacher in treatment of the
severely disturbed child ISRAEL W. CHARNY
- 48 Flexible use of child guidance personnel in a rural medical center
MORRIS PARMET
- 53 The pre-intake phase: The beginning of the intake process
DAVID HALLOWITZ AND ALBERT V. CUTTER
- 64 Perpetuation of non-value AARON L. RUTLEDGE
- 71 A dynamic factor in group work with post-adolescents and its effects on
the role of the leader WILLIAM L. PELTZ AND MARTIN GOLDBERG
- 76 A low-cost psychotherapy program for Essex County, N. J.
EPHRAIN H. ROYFE
- 80 Changing concepts of mental deficiency ROBERT GIBSON
- 87 The attitudes of patients regarding the efficacy of reading popular
psychiatric and psychological articles and books ROBERT S. MORROW
AND MARGARET M. KINNEY
- 93 Music therapy at Westminster Hospital A. E. ROSÉ, C. E. BRAWN AND
E. V. METCALFE
- 105 The role of the consultant as a motivator of action
PAUL HOOVER BOWMAN
- 111 Minnesota's community mental health services ALLEN HODGES AND
DALE C. CAMERON
- 115 Demographic aspects of general paresis BENJAMIN MALZBERG

Book Reviews

- 136 Current practices in mental hospital administration
AMERICAN PSYCHIATRIC ASSOCIATION MENTAL HOSPITAL SERVICE
- 136 Prevention of chronic illness (volume 1: Chronic illness in the United States)
COMMISSION ON CHRONIC ILLNESS
- 137 Principles of perception S. HOWARD BARTLEY
- 138 The nature and transmission of the genetic and cultural characteristics of human populations
MILBANK MEMORIAL FUND
- 139 New frontiers of aging WILMA DONAHUE AND CLARK TIBBITTS, EDS.
- 139 Youth and crime FRANK J. COHEN, ED.
- 140 The patient and the mental hospital MILTON GREENBLATT,
DANIEL J. LEVINSON AND RICHARD H. WILLIAMS, EDS.
- 141 The child in the educative process DANIEL A. PRESCOTT
- 141 Schizophrenia: Somatic aspects DEREK RICHTER, ED.
- 142 The mind of the murderer W. LINDESAY NEUSTATTER
- 143 Remotivating the mental patient OTTO VON MERING AND
STANLEY H. KING
- 144 Psychophysiologic medicine EUGENE ZISKIND
- 145 Mental deficiency L. T. HILLIARD AND BRIAN H. KIRMAN
- 146 The moon is full AILEEN ADAIR
- 146 Helping the visually handicapped child in a regular class
ANTHONY J. PELONE
- 147 Pierre the pelican (new revised and extended series)
LOYD W. ROWLAND
- 148 The guilty and the innocent; my 50 years at the Old Bailey
WILLIAM BIXLEY
- 149 Prescription for survival BROCK CHISHOLM
- 149 Mental health in college and university DANA L. FARNSWORTH

Notes and Comments

THELMA V. OWEN, M.D.

M. G. STEMMERMANN, M.D.

An experiment in public education

It is generally acknowledged that one of the chief obstacles preventing early treatment and complete rehabilitation of patients with emotional disorders is the stigma attached to the words *mental illness*. One of the reasons for this stigma will be erased when the recovered mental patient is willing to discuss his illness as freely as the surgical patient discusses his operation. Efforts by isolated patients, such as Clifford Beers, Jim Piersall and others, have probably been more helpful than the combined words of all professional workers. Yet it is difficult for the average citizen to identify himself with a public figure such as Mr. Piersall—sick or well. Recent public addresses by patients at Ancora State Hospital in New Jersey may very well be more convincing. It is the purpose of this report to describe an experiment which has had considerable influence on attitudes toward mental illness in our community.

The Owen Clinic Institute is a small

private hospital with in-patient and out-patient facilities. In order to provide the best possible psychiatric care for the average middle-class family, fees are kept at a minimum and whenever necessary installment payment plans are arranged. Approximately 50% of admissions have previously had state hospital care. Most patients are housewives, clerical workers or teachers. During the last weeks of hospitalization patients are encouraged to attend mental health, community welfare and other civic meetings in town, as well as concerts and lectures.

Over the years many ex-patients found mutual support following their hospital experience in visiting each other. Finally, they resolved to form a club in order to be helpful to other newly discharged patients,

Dr. Owen is psychiatric director and Dr. Stemmermann medical director of the Owen Clinic Institute in Huntington, W. Va.

as well as to aid families of newly admitted patients. In January 1950 the by-laws adopted included several types of membership. For full membership—source of officers and committee chairmen—a member must have been a mental patient judged "recovered" by the psychiatric director of the institute or a close relative of the same patient. (Consultation service to decide "recovery" status is the psychiatrist's only connection with the club.) Full members, both recovered patient and relative, must be willing to identify themselves by full names in connection with any of the club's public service projects or publicity. Since 1952 every full member has appeared in the role of an ex-mental patient or family member on at least one radio program. Many have also appeared on television. Several are mental health chairmen of their local and county Parent-Teacher Associations.

In the spring of 1956 the county mental health association held a public meeting with a panel of professional people (social worker, minister, physician) who discussed mental health generally and the community's need for a mental health clinic. A member of the ex-patient's club was asked to serve on the panel to speak for the average citizen and his mental health problems. Discussion by all panel members was interesting and informative but the ex-patient stole the show with the story of her illness, hospitalization and readjustment in the community. Her statements, forthright and knowledgeable, stimulated a prolonged question and answer period.

Following the meeting an officer of the mental health association suggested that if one ex-patient contributed so much to a panel, a complete panel of ex-patients might be even more influential. The club agreed with the suggestion and prepared to send a panel to any group requesting a mental health program. A panel usually consists

of two ex-patients, each of whom has had a different type of illness, and a relative to describe the impact of the illness on the family unit. The moderator who introduces the panel speakers is a lay member of the institute's board of directors or the local mental health association board. During the last year 12 panel programs have been given to church circles, women's clubs, men's service clubs and county mental health associations.

The following quotations summarize the introductory remarks of a few of the panelists. Speakers do not read their statement but have put their substance in writing for this report. A question period follows the prepared remarks. Unless addressed to a specific speaker the moderator calls on whichever panelist he believes can best answer each question. Full names are used by the panels, in accord with the club policy.

One former patient, 36 years of age, was never gainfully employed until after discharge four years ago. Now she is working as a hospital housekeeper and is taking correspondence school courses. She was hospitalized 8 months for schizophrenia. She tells audiences:

"September 1952, a red-letter day in my life—I walked into a psychiatrist's office for the first time, referred by my family doctor. The psychiatrist was very kind. She verified what the medical doctor had told me—I was mentally ill and I would need weekly office consultations.

"During the next four months I visited her once each week, meanwhile trying to care for my three children and take part in community life. I planned to return to school in January 1953, but for financial reasons I could not return. This was the straw that broke the camel's back. I had a complete schizophrenic breakdown. I do

Public Education

OWEN AND STEMMERMANN

not remember all details of what I am now going to tell you.

"I had an appointment with Dr. Owen. I did not keep this appointment. She said I called and told her I was too sick to come. Later I went to a justice of the peace, a man I thought to be my friend, told him I was crazy, and asked him to take me to Owen Clinic, 100 miles away. He locked me in a cell, called the state police and they took me to the county jail. There I was locked in with drunks and prostitutes, crying, walking the floor, begging them to let me out and take me to Owen Clinic or call Dr. Owen, my psychiatrist. I was granted neither request.

"I was examined by medical doctors who were not qualified for this, declared insane by the court and committed to a state hospital. My first comment on entering the institution was, 'This is not a hospital; this is just another jail.'

"During the next two days I was given a few electric shock treatments but never saw a psychiatrist. I spent the time in my room alone in bed. Meanwhile all this time Dr. Owen had been trying to locate me. One day she walked into my room at the institution and said 'hello.' I looked at her and thought: 'This is not she; it's just another hallucination.' But it was true she had found me at last, her lost sheep. She came back next day, gathered me up and took me to the 'fold,' Owen Clinic.

"There I received adequate treatment along with the tender loving care that every mental patient needs."

Two other panelists, both 53 years of age, are husband and wife. She was a clerical worker before three months' hospitalization for depressive reaction. After discharge two years ago she returned to her old job. Her husband, a salesman, was engaged to be married to her at the onset of her illness

and was treated in the out-patient department while she was hospitalized.

The husband: "All of you good people listening to me will leave this meeting with the thought, 'That will never happen to me or mine.' This is a perfectly normal reaction and I hope it is true. I thought that way too. But it happened to me.

"I wonder where you should start talking about a subject that is distasteful and shrugged off by most. Should I tell of my experience? Yes, I have been a mental patient. With me it lasted about four months. A short time, true, but to me a lifetime. Fortunately I received early treatment, which made the illness shorter; we know the sooner treatment is started the sooner the patient recovers. My treatment was known as out-patient. I was working the whole time and later when I had recovered sufficiently to talk to others about my illness, to my surprise my behavior at the time was noticed by no one.

"Someone will ask 'How did it happen to you?' I wish I could answer. Unconsciously, meaningless events in everyday life became great factors and were world-shaking in their happening. 'When did it happen?' I can only answer that in retrospect. I remember one day leaving town and driving about fifty miles. I say I remember. Actually, my only memory of the trip is getting into my car and nothing else until I crashed into a bridge, fortunately with no serious consequences.

"You have gone over the edge and have no realization of it. You forsake your family, your friends and have no one to talk to because you are convinced no one will understand and no one will help.

"You are mentally ill. My best advice and the hardest to follow is this: tell somebody about your troubles and worries—someone you have trust in—someone close to you in your family—your minister

—your doctor. What do I do now when a problem arises I cannot cope with? I go to my psychiatrist. But get your troubles outside of you; put them on the table where they can be seen and picked apart. Most of the time you will find they are only shadows.

"Capable psychiatrists, new drugs and treatments all point to case after case of complete cure. Keep remembering this: never forget the one who is ill needs your love and understanding more than ever. I know because I have had the experience.

"And to you who are perhaps wondering if I have forgotten someone we can always turn to, I say go to God. He will never turn His back and will always answer your prayers. I know how He helped me and I am convinced saved my life.

"God grant it never happens to you who listen; but remember none of us is immune to heart disease or cancer and mental illness can strike any of us."

The wife: "Have you ever had a gnawing anxiety that you couldn't put your finger on? Just anxious for no apparent cause? Have you ever lain awake at night thinking you heard music? The same tune over and over and over? Or the voices of people in the apartment next to you or under you talking over and over and over in the same tone of voice, till you think you will have to get up and scream at them?

"I had a home, but I leased it and moved into an apartment uptown. This was before I realized how sick I was. I thought I would be happier uptown close to my work, with no yard to tend. My sons had married and moved away. That didn't bother me especially, because I had prepared myself for it, or thought I had. For a time I was fairly satisfied in the apartment and then the walls began to close in on me. I had no neighbors, as I had when I lived in my home. When I went in and closed the

door I was completely alone. No one to talk to—just four walls. I became so distraught that I was afraid to go to the fire escape to empty the garbage into the incinerator for fear I would jump off. Not afraid to die, for I felt that I would really welcome death to the life I was living—but afraid if I did jump I would only be crippled and become a burden to my family. I had aches and pains all over my body. The doctors I went to told me I had arthritis and they gave me shots and pills for that. I am not criticizing the doctors. They are all good men—but they just didn't go deep enough to find the real cause of my distress.

"Finally, I became so ill and tired that I went into a clinic for two weeks' rest, and at last I had found a doctor who understood. While there he gave me insulin shock treatment and I came home feeling well. But it didn't last. I was to report back to him at the end of a week. Within that week I had regressed to my old condition of anxiety and fear. The night before I was to report back to him, I put the man I loved out of my apartment with the sentence that he was not to come back—ever. I was beside myself.

"I went to the doctor the next day for my check-up and he saw immediately my condition. He said, 'My advice to you is to see Dr. Owen and to go into her clinic for treatment.' Like most people I was stunned. I said, 'But that is a mental hospital!' Even though I knew in my heart that I was mentally ill, I hesitated to admit it. His answer was, 'Either do what I say or you will end up in the state hospital against your will.' I knew if I ever went to the state hospital it would be against my will, because I had been a visitor there and I knew the conditions. I went back to my apartment and brooded over the thought of being a mental patient anywhere.

Public Education

OWEN AND STEMMERMANN

"Then I ran away. I called a friend I knew I could trust and she took me to her home and kept me until I saw Dr. Owen and made arrangements to enter the clinic. No one but this friend knew where I was for some time. This is not a plug for the Owen Clinic, but I found a home away from home. I was given thorazine to calm me down. I was kept busy every minute, attending classes in psychotherapy, English, occupational therapy, outside raking leaves and even sawing logs for the fireplace. I learned to live again without fear and without anxiety—and finally I married the man beside me and we are having a happy home life. True, I still have anxious, depressed moments at times, but my good Dr. Owen tells me this is to be expected. These times are becoming farther and farther apart. I am well and I am getting better."

A fourth panelist, 42 years of age, is the husband of another club member who was discharged after six months' hospitalization. He says to audiences:

"When my wife became ill, I found myself in a most difficult situation because I had no conception of mental illness. I saw the psychiatrist weekly in regard to my wife's progress but you do not grasp the reason or cause for mental illness in a short time.

"One of the difficulties I had was understanding the treatment used. As a rule, you think of sick people as needing rest and quiet, but for mentally sick people it is just the opposite. This was brought home to me when I found my wife hoeing in the garden, participating in all types of sports, taking courses in everything from handicrafts to current events.

"It is now 10 years since my wife was discharged. Prior to hospitalization she had never worked outside the home and in fact was too fearful to leave the house un-

escorted. She depended upon me for everything. This has all changed. It is the former mental patient who is now the stabilizing influence—the one our son and I depend upon. In addition, she works as secretary to the principal of our neighboring grade school. Formerly, doctors' bills kept us perpetually in debt. Now we own our home and next year we are sending our son to college.

"The mentally ill *can* get well. I've seen it happen."

Statistical evaluation of improvement in public attitudes because of the Owen Clinic Club and its panels is impossible. We know of two results, one discouraging, the other hopeful. It is frequently discouraging to club members to overhear or have it said directly: "But, of course, *you* were never very sick—like patients in the state hospital." It is hoped that the panelists will dispel this misconception.

The hopeful sign is the fact that with one exception no club member has been refused a job following discharge although they never hesitate to admit prior mental illness and usually give Dr. Owen's name as reference. The one exception is a girl who returned to her factory job, completed high school by correspondence courses and then applied for job training in a telephone company. The personnel manager, who knew her past history, hired her and after a probationary period approved her for full time employment. The medical staff, however, general practitioners working part-time, refused to approve her appointment because of "company policy." This ex-patient is now working as a secretary in an automobile agency.

This case may be an exception. If it is not, one may conclude that the Owen Clinic Club has been less successful in changing attitudes of the general practitioner than in influencing attitudes of the general public.

ROBERT SOMMER, Ph.D.

Visitors to mental hospitals

A fertile field for research

The visiting of patients in mental hospitals by interested relatives and friends has received very little attention. Lidz, Hotchkiss and Greenblatt (3) comment that "so little has been done in this field that (we) cannot do more than raise questions or delineate areas for future investigation noted in the few exploratory studies." Far more has been written about community volunteers and visiting entertainers than about visits by the patient's own family and friends. It has been the writer's experience

that more hospitals have a coordinator of volunteer services than have a full-time person to meet and talk to relatives. Often this latter task is performed in perfunctory fashion by an impersonal figure at an information booth or hospital switchboard.

However, many relatives are not discouraged by long journeys to isolated hospitals, inadequate visiting rooms, or patients whose conditions remain unchanged over the years. Yet we know little about the types of patients who receive visitors and the effects of these visits. Occasionally a nurse will notice that a patient is more relaxed after a visit, or he will begin to speak about going home himself, but on the whole the visiting of patients is largely an unknown quantity as far as mental hospitals are concerned. Research is lacking. Many hospitals consider visiting hours as something that is expected of them and

Dr. Sommer is research psychologist at the Saskatchewan Hospital, Weyburn, Canada. He writes: We are grateful to Miss Olga Koshman for collecting the data and checking the case files of the patients. Dr. Humphrey Osmond, superintendent of the Saskatchewan Hospital, provided the stimulus and encouragement for the study. This research was aided by grants from the Rockefeller Foundation and the Ottawa Department of Health and Welfare.

Visitors to Mental Hospitals

SOMMER

make no effort to increase their therapeutic potential, either for the patients or for the relatives.

Solomon (4) maintains that visitors to mental hospitals usually come away depressed and discouraged. However, in a recent study Sommer and others (5) showed that a *planned* program for visitors resulted in a marked improvement in attitudes towards the hospital and awakened a desire to do volunteer work for the hospital.

The purpose of this study is to investigate some of the characteristics of those patients who receive visitors. We hope to determine the relationship between receiving visitors and the patients' present age, age at first admission, length of hospitalization, sex, and distance of home residence from the hospital. We also hope to see if those patients who receive visitors show a higher rate of discharge than the patient population as a whole.

METHOD

The study was carried out at a 1,600-bed mental hospital. The hospital is within the city limits of a town of 8,000, although the surrounding countryside is primarily agricultural. The hospital is 75 miles from the nearest large city (100,000 inhabitants). Relatives usually drive to the hospital and many come in large family groups. They register at the information desk where a man notifies the patients' ward of their arrival.

From the register at the information desk a list was obtained of patients who had received visitors during the 3-week period from October 1 to October 21, 1956. A record of all visitors had been kept routinely by the clerk at the desk. The information he obtained included the visitor's name, present residence, relationship to the patient, and the patient's name. When all

duplications had been removed, this yielded a total of 191 patients who had received visitors during this period.¹

To determine in what way this group differed from the patient population as a whole, it was also necessary to obtain a random sample of all patients in the hospital during this period. From the hospital roll of October 17, 1956 the name of every tenth patient was selected. As the hospital roll had kept the sexes on different lists, our sample was stratified according to sex but random according to all other factors. That is, the number of men and women in the comparison sample was in perfect proportion to the number in the total patient population.

This procedure yielded a total of 185 names. To provide samples of equal size, six more patients were randomly selected from the hospital roll and added to the comparison group. This resulted in two samples of 191 patients each: one containing patients who had received visitors and the second a random sample² of all patients in the hospital.

Each patient's file was consulted and the following information obtained: present age, age at first admission, total length of hospitalization,³ sex, and home residence.

¹ The roster of visitors included only friends and relatives who came after the patient had been admitted. This excluded all relatives who accompanied the patient at the time of admission and all groups of volunteers who did not come to see specific patients. Also removed were the names of several patients who had died within a week after the visit of the relatives; these were cases where the physician had realized the patient was dying and had notified the relatives who came for a last visit.

² For the sake of simplicity, this group is referred to as a "random sample" although it is stratified according to sex.

³ Computed by adding up all periods of hospitalization. If there were several admissions, the length of each period was summed and the total was used.

TABLE 1

Percentage of patients in each age range

	PRESENT AGE OF PATIENTS							
	<i>Less than 20</i>	<i>20-30 *</i>	<i>30-40</i>	<i>40-50</i>	<i>50-60</i>	<i>60-70</i>	<i>70-80</i>	<i>Over 80</i>
Patients receiving visitors (N = 191)	2.1	6.8	15.7	22.0	13.6	14.7	17.3	7.9
Random sample (N = 191)	1.6	5.8	10.5	19.4	19.9	19.9	16.8	6.3

* Literally this is 20.1-30, the next column 30.1-40, etc.

As this research was carried out approximately 14 months (December 1957) after the criterion date of October 1956, it was possible to see how many patients in each group had been discharged in the intervening period.

PRESENT AGE

Table 1 shows the percentage of patients in each age range for both the patients with visitors and the random sample of patients. Analysis of these data establishes that there is no relationship between the present age of the patient and whether or not he re-

ceives visitors. The proportion of young to old patients who received visitors parallels the proportions of young to old patients in the hospital population. A breakdown of the age groups by sex did not reveal any significant trends.

AGE AT FIRST ADMISSION

Table 2 shows the ages at first admission of the patients with visitors and of the random sample of patients. It shows a trend for the patients who received visitors to be somewhat older at first admission than the general run of patients in the hospital.

TABLE 2

Percentage of patients in each age range at time of first admission to hospital

	AGE AT FIRST ADMISSION							
	<i>Less than 20</i>	<i>20-30</i>	<i>30-40</i>	<i>40-50</i>	<i>50-60</i>	<i>60-70</i>	<i>70-80</i>	<i>Over 80</i>
Patients receiving visitors (N = 191)	5.8	22.0	20.4	12.6	8.9	13.6	12.6	4.2
Random sample (N = 191)	12.6	26.7	24.1	14.1	5.8	8.4	4.7	3.7

Visitors to Mental Hospitals

SOMMER

TABLE 3

Percentage of patients at varying lengths of hospitalization

	LENGTH OF HOSPITALIZATION					
	<i>Less than 1 year</i>	<i>1-5 years</i>	<i>5-10 years</i>	<i>10-15 years</i>	<i>15-20 years</i>	<i>More than 20 years</i>
Patients receiving visitors (N = 191)	17.8	41.9	13.1	7.9	8.9	10.5
Random sample (N = 191)	2.1	22.5	13.1	9.9	13.6	38.7

When these data are divided at the median, the table shows that significantly more patients who received visitors were over 40 years old at first admission than would be expected on the basis of the proportions in the total patient population ($X^2 = 8.00$, $p < .01$).

The average age at first admission for the patients with visitors was 46.3 years while the average age at first admission for the random sample was 39.3 years.

LENGTH OF HOSPITALIZATION

Table 3 shows the length of hospitalization of the patients who received visitors and of the random sample of hospital patients. There is a striking difference between the groups. Patients who received visitors have been in the hospital significantly less time

than patients who did not receive visitors during the observation period. In fact, there is a direct relationship evident in this table between the length of hospitalization and the percentage of the group that received visitors.

The average length of hospitalization for the random sample of the hospital population was 16.6 years while the average length of hospitalization for the patients who received visitors was 7.4 years. This difference is highly significant ($t = 8.83$, $p < .01$).

It is surprising to find that there is no relationship between the present age of the patient and whether or not he received visitors, although there is this marked relationship between receiving visitors and length of hospitalization. This surprise would be based on the belief that there should be a

TABLE 4

Length of hospitalization of patients in random sample at different age levels

	PRESENT AGE						
	<i>Less than 30</i>	<i>30-40</i>	<i>40-50</i>	<i>50-60</i>	<i>60-70</i>	<i>70-80</i>	<i>Over 80</i>
Median years in hospital	4.0	10.0	18.0	22.0	23.5	14.0	5.5
Number of cases	14	20	37	38	38	32	12

TABLE 5

Age at first admission of patients in random sample discharged within a 14-month period

	AGE AT FIRST ADMISSION						
	<i>Less than 20</i>	<i>20-30</i>	<i>30-40</i>	<i>40-50</i>	<i>50-60</i>	<i>60-70</i>	<i>More than 70</i>
Patients (N = 21)	2	6	1	5	1	6	0

direct relationship between the present age of the patient and the length of hospitalization. However, this assumption is incorrect as there is definitely a curvilinear relationship between these variables. This is attributed to the fact that many of the geriatrics patients at the hospital are comparatively recent admissions. In fact, the oldest group of patients in the hospital has proportionally more patients in the hospital for less than five years than the patients who are between 30 and 40 or between 40 and 50 years old. The median length of hospitalization for patients in each age range in the random sample is shown in Table 4.

DISCHARGES IN INTERVENING PERIOD

As the criterion visiting period was October 1956 while the examining of the case records took place in December 1957, it was possible to see which of the patients had been discharged during the intervening 14 months. The results showed that 50 of the patients who had received visitors were discharged during this time while only 21 of the random sample had been discharged.⁴

Although it does not directly concern the matter of visiting, it is interesting to note some of the characteristics of the group of

21 patients of the random sample who were discharged in this period. Tables 5 and 6 show the length of hospitalization and the age at first admission of this group. If these figures are compared with those in Tables 1 and 3, we find that there is no relationship between age at first admission and whether or not the patient has been discharged in the 14-month period. However, there is a direct relationship between the length of hospitalization and whether or not the patient has been discharged during this period. Although only 25% of the random sample of hospital patients were in the hospital less than 5 years, 86% of the patients (in the random sample) who were discharged within the 14-month period were in the hospital 5 years or less. There were no relationships between discharge in this period and the present age and sex of the patient.

SEX OF PATIENT

The actual composition of the hospital patient population at the time of the study (October 1956) was 59% male and 41% female. However, of the patients who received visitors 44% were males and 56% were females. This is a statistically significant difference ($X^2 = 8.20$, $p < .01$) and shows that the female patients received proportionately more visitors than the male patients.

⁴ Fifteen of the random sample and 13 of the patients with visitors had died during this period.

Visitors to Mental Hospitals

SOMMER

TABLE 6

Length of hospitalization of patients in random sample discharged within a 14-month period

	LESS THAN 1 YEAR	1-5 YEARS	5-10 YEARS	10-15 YEARS	15-20 YEARS	MORE THAN 20 YEARS
Patients (N = 21)	4	14	0	1	2	0

DISTANCE FROM THE HOSPITAL

Table 7 shows the percentages of the patients as classified by the distance that their home residences are from the hospital. One might expect that patients who had lived closer to the hospital would receive more visitors than those who had lived at a greater distance. This is not supported by these data. Patients who received visitors had lived proportionately the same distances from the hospital as the random sample of patients.

DISCUSSION

Of the variables examined in the study, the length of the patient's hospitalization is

most closely related to whether or not the patient has visitors. The longer the patient is in the hospital the less likely he is to have visitors. It is important to note that this is relatively independent of the patient's present age. This is further evidence for the disculturating effects of large mental hospitals. In other studies (6) we have shown the minimal level of interaction that occurs on mental hospital wards and the paucity of recreational activities. In a previous paper we compared our patients to people sitting in a waiting room for a train that never appears. This study shows that the longer the person has been waiting, the less likely he is to leave the room or have

TABLE 7

Distance from hospital of patients' home residence

Miles from hospital	PERCENTAGE OF PATIENTS	
	Patients with visitors	Random sample
0- 50	11.6	9.4
51-100	38.7	32.2
101-150	18.8	25.1
151-200	9.4	8.8
201-250	13.3	8.2
251-300	5.5	14.0
301-350	2.2	1.8
Over 351	0.6	0.6

his vigil interrupted by a visit from friends or relatives.

We hope soon to be able to study time perception in long-stay patients. On the basis of some pilot research there is evidence that the patients' sense of time is grossly distorted when it comes to matters of years or decades. Some patients speak of the outside world in terms of the world they had known 30 years ago (2). A few express a desire to leave the hospital "because they are needed at home" when the home they had left several decades ago no longer exists.

Although there was a striking relationship between length of hospitalization and receiving visitors, we are not able to infer a causal relationship between the two variables. It seems logical that receiving visitors might awaken a desire to go home in a patient, or show him that he still has a home to return to, but there are still other possibilities. One might think of the large isolated mental hospital as a grossly dis-cultivating social institution; the longer the patient is in the hospital the more de-socialized he becomes and the more likely his relatives are to consider him incapable of living outside again. In this case the relationship between visiting and length of hospitalization would be a by-product of the dis-cultivating effects of the hospital, rather than a causal connection. However, we are able to state definitely that a marked relationship between these two variables *does* exist, and it will require some more specific research to establish the precise nature of the connection.

For example, we will need to know the *effects*, both immediate and over time, of visits to various types of patients by their relatives. At present we often assume that such visits are inherently beneficial to patients and relatives. Perhaps it is possible to learn if this is really so and to what extent the hospital administration could in-

crease the therapeutic value of the visits. Do we really know anything about the possibility of using selected relatives as volunteer workers? Greenblatt, York and Brown (1) mention that this has been tried at Boston Psychopathic Hospital but we do not know the outcome of this program and whether it could be extended to more isolated institutions with fewer staff members. It is imperative to know why some relatives will visit a patient regularly and others will never come to the hospital. How much of this is owing to negative stereotypes about the hospital? To a lack of knowledge about visiting hours? To a lack of encouragement from the hospital administration?

These are important questions and we hope to learn some of the answers by interviewing relatives who visit the hospital and also by sending a questionnaire to patients' relatives who never have visited the hospital.

SUMMARY

The characteristics of patients who receive visitors and the effects of the visits are extremely fertile fields for research. In this study, the relationships were investigated between whether or not a patient received visitors during a 3-week criterion period and his present age, age at first admission, length of hospitalization, sex, distance of home residence from the hospital, and whether or not he was discharged within a 14-month period.

During a criterion period (October 1-21, 1956) the records of all patients who received visitors were examined and information on these factors was recorded. The same was done for a random sample of equal size from the total hospital population. The two samples were then compared to determine in what way the patients who

Visitors to Mental Hospitals

SOMMER

received visitors differed from the random sample of the total hospital population.

The results disclosed that there was no age difference in the two samples. However, the patients who received visitors tended to be slightly older at first admission than patients in the general hospital population. There was a marked relationship between length of hospitalization and whether or not the patient received visitors. The patients who had received visitors averaged 7.4 years in the hospital while the patients in the random sample averaged 16.6 years in the hospital. Female patients also received more visitors than would have been expected on the basis of the proportion of females in the total hospital population. The visiting was unrelated to the distance of the patient's home residence from the hospital. Of those patients who received visitors, 50 were discharged within 14 months after the criterion period, while 21 patients in the random sample were discharged. Whether or not the patients in the random sample were discharged was

highly related to the length of hospitalization, but unrelated to the present age of the patient.

REFERENCES

1. Greenblatt, M., R. H. York and E. L. Brown, *From Custodial to Therapeutic Patient Care in Mental Hospitals*. New York, Russell Sage Foundation, 1955.
2. Lanzkron, J. and W. Wolfson, "Prognostic Value of Perceptual Distortion of Temporal Orientation in Chronic Schizophrenics," *American Journal of Psychiatry*, 114(February 1958), 744-46.
3. Lidz, T., G. Hotchkiss and M. Greenblatt, "Patient-Family-Hospital Interrelationships," in *The Patient and the Mental Hospital*, edited by M. Greenblatt and others. Glencoe, Free Press, 1957.
4. Solomon, H. C., "The Twenty-four Hour Care of the Patient," *Mental Hospitals*, 8(June 1957), 3-6.
5. Sommer, R. and others, "An Evaluation of a Mental Health Week Program," *Mental Hygiene*, 42(April 1958), 195-210.
6. Sommer, R. and others, "Displaced Persons: Elderly Patient in a Large Mental Hospital," *Geriatrics*, 13(1958), 653-61.

Form and function

Caudill concludes that the present form of the psychiatric hospital has been largely determined by historical circumstances, and that psychiatric hospitals in the future may be structured very differently depending upon specific therapeutic goals. He suggests several ways in which psychiatric hospitals might be changed so as to become true therapeutic communities.—Excerpted with the permission of the Institute of Living (Hartford, Conn.) from a review of *The Psychiatric Hospital as a Small Society* by William Caudill (Cambridge, Harvard University Press, 1958) in the *Digest of Neurology and Psychiatry*, 26 (July 1958), 299.

TED O. IRWIN

Socialization and sewing as the means to an end

Using occupational therapy sewing groups as a means to an end in group therapy is not new, but a project which is now underway at the Larned State Hospital has shown such excellent results that it is believed worthy of passing on to other institutions.

The coordinator of adjunctive therapies instigated the project. Not having enough psychiatrists or psychologists employed at the time to work on the project, the superintendent decided to utilize the coordinator as group therapist, an occupational therapist as sewing therapist and the industrial therapy head as observer. During the first two weeks in March 1957 the doctor in charge of the regressed ward of the hospital was contacted and asked to select seven or eight women who had been in the hospital

for some time, who had shown little improvement during their stay and who could possibly benefit by a long-range sewing program. Seven names were submitted and the group started work on March 15. The average length of stay in the hospital for the seven had been six and a half years. During this time most of them had had shock treatment and milieu therapy but very little progress had been noted on any of these patients.

Patient A, a 33-year-old housewife, was admitted to the hospital in 1955 and her illness diagnosed as schizophrenic reaction, chronic undifferentiated type with partial remission. This patient's father had been in a mental institution since 1938. She is the mother of four children and has shown very little progress since her admission to the hospital.

Patient B, a 44-year-old single woman

Mr. Irwin is coordinator of adjunctive therapies at the Larned State Hospital in Kansas.

Socialization and Sewing

IRWIN

with a diagnosis of manic-depressive psychosis, was admitted to another institution in 1939 and after spending nine years in that hospital was transferred to the Larned hospital in 1948. She had spent 14 years of her life in mental institutions.

Patient C, a 32-year-old housewife with no children, had been diagnosed as having schizophrenic reaction, chronic undifferentiated type, and had been in the Larned State Hospital for almost three years.

Patient D was admitted in March 1956 and was given a diagnosis of schizophrenic reaction, paranoid type. This woman is the mother of four children and has had considerable difficulty in adjusting to her family and community during the last eight or nine years. She is 38 years of age and has shown little or no recovery since entering the hospital.

Patient E is a 47-year-old single woman with a record of having worked in telephone exchanges for 20 years prior to entering the hospital. She was admitted almost eight years ago and at the time of admission was listed as suicidal. She has one uncle who has been judged insane, another who has been listed as a religious fanatic, and several relatives who are said to be neurotic. Her diagnosis is schizophrenic reaction, paranoid type. She has hallucinated during her stay in the hospital and for the most part has been extremely hostile during her entire stay.

Patient F is a 56-year-old married woman with no children who was admitted to the hospital four and a half years ago with the crime of murder listed on her chart. Her diagnosis is manic-depressive, depressed type, with a borderline mental deficiency.

The last of the group of patients has been in the state hospital for 16 years and has spent about 25 years of her life in and out of hospitals. She is now 41. Her father died as a mental patient at the Larned State

Hospital. Her grandmother died in another state institution and the family has a long record of mental illness. She is classed as a psychopathic personality without psychosis.

Most of these patients have grown up in a neurotic atmosphere. Fathers, mothers, uncles, aunts and other members of the family have had mental illness and these patients have been raised in this atmosphere. Almost every one of these women has had a very real problem in relating both to her own family and to the community. A reading of the charts on each of the women shows that there has been an intrapersonal difficulty outside of the hospital which has forced them to be committed to this institution. These seven were selected with the idea that perhaps by working and talking together every day they would be able to solve a number of their own problems. Also, working with outside groups on the sewing projects and feeling that they are needed would provide them with a family tie which might help them to solve their difficulties.

After the list had been compiled the coordinator contacted the head of the welfare program for Pawnee County and asked for a list of needy families in Larned who could use clothing. The head of the agency gave three names, and after checking the three families one was selected to be "adopted" by the group of seven patients. This family consisted of a mother, a father who had been in a hospital for three months with a heart attack, and 7 children ranging in age from six months to 16 years.

At the initial meeting the coordinator, the occupational therapist and the observer explained the purpose of the group to the seven women patients. On the second day the group was taken to Larned to meet the family they had "adopted." The mother of the family talked to the patients, visited

with them at great length, and told them approximately what the family would need in the way of clothing for both the summer and also for school days in the fall. The group spent approximately an hour in the home of this family. During the next few days the occupational therapist went over plans with the group as to what type of clothing could be made for this family—dresses for both the girls and the mother, shirts for all the boys and the father, nightgowns and pajamas for both the boys and the girls, sunsuits for both boys and girls, bedding for the entire family, dolls for the girls, sunbonnets and many other items. About April 1 the group began meeting regularly an hour a day on Monday, Tuesday, Wednesday and Thursday and spent these hours in sewing for the "adopted" family. On Friday the coordinator and observer met with the group to discuss events that had come up during the week.

At first the patients were hesitant to speak out in group therapy. But the longer they worked with the therapist the better they became acquainted with each other and the more harmoniously they got along. During the Friday discussions they began more and more to relate their problems to the group and to help solve each other's difficulties. Psychiatry teaches that the nucleus of finding out about one's own problems is in discussing them with other people, and this soon came about at the Friday meetings. The women began to relate to the downtown family they had "adopted" and began investing of themselves in the group project.

Practically all of them had had a feeling of failure at the time they entered the hospital. But as the articles of clothing began taking shape they slowly began ridding themselves of this feeling of failure; they felt they were, for the first time in their lives, actually doing something worth while for

someone else. Most of them had the problem of getting along with others and this took some time to dispel, even working as a group. There was a great deal of friction among them during the first two months of the project. Only one sewing machine was available for the entire group and a great number of bitter arguments arose over who was going to use the machine. Such things as the use of scissors, tables for laying out patterns, the use of patterns and other items also brought about rather heated discussions. As time went on and the group met daily, many of these problems dissolved and now the women may be found any day in complete harmony, with no arguments as to the use of the machine or materials. Many times the patients now work together with one holding the pattern while the other one marks, or one may be found cutting materials for another patient who is sewing on the machine. It was soon found that the one hour given to sewing classes was not long enough and the periods have been lengthened to an hour and a half daily. During the last six weeks there has been only one argument between patients, this involving a pair of scissors, and the patients themselves solved it quickly with no help from the therapist. During the entire time the occupational therapist in charge has been strictly a spectator giving only a word of advice here and there to the patients. In this way the patients have begun to depend on their own judgment and reasoning and are thus solving their own problems. The Friday discussions, which at first brought out only the gripes against such personnel as doctors, psychologists and other members of the staff, have now arrived at a point where actual problems of the patients are brought out by the patients themselves and are being solved by group discussion.

By June the group felt that they had enough clothing made to take into town

Socialization and Sewing

IRWIN

and give to the family so that they could get the use of it during the summer months. Playsuits and other items for summer wear were taken in and the group met again with the lady of the house and the children at which time she served punch and cookies to the patients. Two of the children modeled their garments and this did a great deal to bring back the home life situation to those patients who had had children before entering the hospital. The group came back to the hospital more determined than ever to make more clothing for the children to use in school. On September 5 they again made a trip to Larned to take clothing.

A check at this time revealed between 55 and 60 completed articles of clothing had been made by this group of seven so-called "regressed" patients. Most of the clothing made would stand inspection with manufactured articles. The total cost of material and patterns up to this point was \$22.85.

For the most part the patients by this time had a feeling that they were definitely needed by the community and that they were for the first time contributing something that was extremely helpful to other people. This in itself did a great deal to rid them of the feeling of failure they have had for the past many years. The coordinator reinforced their feeling of being needed by laying out several possibilities for service to other patients. The women themselves decided to make stoles and booties for the women in the geriatric section. (All of these geriatrics patients are over 65 and even though the buildings are well heated they like to have stoles to wear about their shoulders and to wear the booties in the day hall while watching television or reading.) The new project has gone so well since it was started in September that not only are the members of our group making stoles and booties for the

geriatric section but they have also taken on three more female wards and hope to have between 90 and 100 complete outfits ready by Christmas to give to these wards. Since the hospital has no funds available for such a project, other than for use as occupational therapy materials, which do not include flannel for the stoles or booties, it became necessary to find "good fathers" to supply funds. A local store was having a sale on flannel at less than half price. The leader of the group contacted five of the civic organizations in Larned, getting checks ranging from \$5 to \$10 from each one, and with this money bought enough material to complete the entire project.

From March 15 to November 15 three of the original group of seven women have left the hospital and four new members have been added. Of the four remaining in the group who were in at the start of the project, two are now definitely planning to leave the hospital. Because of court charges another cannot be released outright but her case is in the planning stage for boarding home placement. Only one of the original seven has shown little or no progress since the group was formed.

The socializing among the patients has produced tremendous strides in progress among at least six of the original group, and the discussions on Friday are making the patients aware of their own problems and of the fact that most of these can be worked out by themselves. Patient A, after being in group therapy for four months, was released on July 29 for a trial visit and is now making a satisfactory recovery at home. Patient B has recovered enough since joining the group that she has now been transferred to a hospital in her home town where she can spend a considerable amount of time with her family. Patient C worked with the group for eight months

and has now returned to her husband for a trial visit and is at the present time making satisfactory progress on the outside. Patient D is now at a stage where it is felt she can be released from the hospital but she cannot return to her home environment and other members of the family are unable to help her at the present time; our social service department is now making plans to find her a job in a town close by and she should be released by the time of the publication of this article. Patient E has reached a point at the present time, through group activity and socialization in the sewing project, where she is planning to take at least a part-time job on the outside and continue her stay and group activities in the hospital until she is capable of functioning full-time on the outside. Patient F was the slowest of the group to take part in the activities but at the present time she is functioning extremely well; if the charges against her can be dropped or if she can be paroled, she is planning to go to a boarding home where it is felt she will

function extremely well. Patient G is the only one of the group who has shown little or no progress since becoming a part of the group. The aides and attendants on the section say that the sewing project has definitely reduced her hostility but aside from this she has made little progress. The diagnosis is sociopathic personality, and it is a well-known fact that very little can be accomplished psychiatrically with patients with this diagnosis.

This group project has been so outstanding that plans are now being made to start another group similar to this, perhaps with patients who are not in quite such a regressed state and who have not had so long a stay in the hospital. If this plan is completed, it will mean that possibly 16 women will be receiving help instead of the original seven which formed the first group. Since the work of this group has been so outstanding it has been asked that in the budget for next year funds be set aside for material and other items for use by these groups to continue them throughout the entire year.

RUTH LATIMER

A new hypothesis in infant adoptive placements

Since the beginning of agency infant adoptive placements, emphasis has always been on matching the child and the adoptive family. Indeed, one of the gratifications of the adoptive worker has been in the neatness of this matching. Did the infant look like his adoptive parents? Fine! Did he appear to resemble them in his "infant personality"? Even better! And what about IQ? Did the baby's parents as well as the adoptive parents go to college? Delightful! Or even if both just had high school, or grade school, all was well as long as they matched.

From time to time there have been murmurs of discontent with this hypothesis of matching. Adoptive parents have protested as they waited for this chosen child, that agencies were being too fussy. A social worker having observed the emergence of

a good student from "poor heredity" questioned the limitation of this heredity if contra-influences were sufficiently powerful.

Sometimes it appeared that these influences didn't even have to be very strong. Love, security and meeting their basic physical needs, for example, often wrought near-miracles in the development of children in temporary custody of an agency. Suddenly a child works through adolescent inertia and becomes a new person in and out of the classroom. A child diagnosed as retarded finds security and love and growing self-confidence with the stimulus of small successes and develops into a normal, happy, productive child under foster home care.

Mrs. Latimer is supervisor of adoptions at the Children's Home of Cincinnati.

Cumulatively, the social worker is constantly impressed with the possibilities of children properly stimulated by loving substitute parents. And this despite the most discouraging heredity.

The adoptive worker, however, is always haunted by the spectre of permanence. This is the whole emphasis in adoptive placements. We dare not take chances. A family's future happiness is at stake. Imbued as we are with the desire not to place a child where more will be expected goal-wise of him than he can do, and with the desire that adoptive parents never be disappointed, we hesitate to change policies and procedures which seemingly have withstood the test of time.

Nevertheless, as our agency did more adoptive placements of emotionally disturbed, difficult-to-place children, we *had* to change procedures. Obviously we do not "match" our emotionally disturbed child by placing him with emotionally disturbed parents. On the contrary, we deliberately search for a couple who, in the emotional and physical environment they provide, will counteract the "bad start" the child has had.

The ramifications of this practice are apparent. To return to infants, the problem was in the heredity as revealed in the social history. A considerable number of infants were considered non-adoptive unless our matching theory gave way to a different hypothesis.

A basic fact which had to be accepted was that purely scientific considerations could not be controlling in any new approach. Many of the appurtenances of pure research are lacking in the operation of any social agency. We believe, however, that philo-

sophic research can be productive. As has been said: "When we restrict our effort to science, the method of accuracy, we fail to move on to greater prophecy, the method of qualitative adequacy."¹

A review of the literature reveals again the lack of research in adoptive work which has always been a handicap to agencies in projecting new hypotheses and/or in evaluating them once put in use.

In 1948, in the *Journal of Genetic Psychology* and in the same journal in 1949 are reports from the Iowa Child Welfare Research Station of the State University of Iowa which are pertinent to our hypothesis.

In the interest of brevity only the conclusions from these articles will be quoted. From the first, the author offers two statements:

- "Children of mothers with low intelligence or from fathers with low occupational status, or from a combination of both, placed in adoptive homes in infancy, attain a mental level which equals or exceeds that of the population as a whole."

- "The frequency with which cases showing mental retardation appear is no greater than might be expected from a random sampling of the population as a whole, and the frequency with which cases having superior intelligence appear is somewhat greater than might be expected from a random sampling."

From the second study, the conclusions from the material are as follows:

- "The above-average mental development of the children adopted in infancy has been maintained to early adolescence."

- "The educational or occupational data available for foster or natural parents in the typical social history record are not sufficient to predict the course of mental development of the children. Other fac-

¹ R. B. Raup, "On Making Research Significant and Vital," *Advanced School Digest*, 6(Oct.-Nov. 1940), 1-11.

Infant Adoptive Placements

LATIMER

tors, primarily emotional and personal and probably located in the foster home, appear to have more significant influence in determining the mental growth of the children in this group."

● "The intellectual level of the children has remained consistently higher than would have been predicted from the intellectual, educational or socio-economic level of the true parents and is equal to or surpasses the mental level of own children in environments similar to those which have been provided by the foster parents."

"The implications for placing agencies justify a policy of early placement in adoptive homes offering emotional warmth and security in an above-average educational and social setting."

At one stage social workers were greatly influenced in making infant placements by the theory of developmentalism. We were impressed with the use of growth gradients in evaluating a child's potential. We often lost sight of the fact that these are neither inflexible nor definitive.

Gesell and Ilg say "... it would be sadly gratuitous to infer that adult ways of life are due to the imperfections of children. Sound inheritance greatly reduces these imperfections and *wise management brings the others under control.*"²

Inheritance is important in prognosticating. But inheritance is frequently evaluated without norms or standards and without objectivity. Anyone looking at the "inheritance" of Lincoln or Edison could hardly have predicted their remarkable futures. Sir Frederick Banting, brilliant pioneer in research on diabetes and cancer was born on a frugal farm in Allison, Ontario, Canada.³ William Osler, one of the great founders of modern medicine, was born in a family of nine at Bonhead on the edge of the wilderness in what was Upper

Canada; his mother was herself an adopted child and his father was a sailor turned clergyman.⁴

Query: Had these men come to an adoption agency as newborn babies, what level home, based on social history and heredity, would we have chosen?

The answer is fairly obvious: We would not have chosen a so-called superior home. Yet somewhere and somehow these individuals, through interpersonal relationships and perhaps a "plus" to which we will refer in more detail later, far surpassed their origins.

It is our belief that we cannot predetermine by a child's family background or by his growth gradients precisely what type of home is best suited to him. Our agency has developed a tentative hypothesis: The limitations of heredity are essentially limitations only to the degree that they are not overcome by appropriate emotional, intellectual and social stimulation and satisfaction.

We have operated gingerly under this hypothesis. With the very few cases involved we have tried to examine objectively the results of practicing within this hypothesis. Risk-taking has been held to a minimum and the danger of damage to our child through possible overplacement is controlled by the adoptive family, who can accept the child at whatever level his potential may finally be established.

The material which follows is essentially a preliminary report. It represents one point of view—probably a controversial one. Some readers will reject all, others

² Arnold Gesell and Frances L. Ilg, *Child Development* (New York, Harper & Brothers, 1949), 453.

³ Lloyd Stevenson, *Sir Frederick Banting*, 2nd ed. (Springfield, Ill., Charles C Thomas, 1947).

⁴ Harvey Cushing, *Life of Sir William Osler*, vol. 1 (New York, Oxford University Press, 1940).

disagree in part. Some will read skeptically, and this we welcome. (As Santayana says, "Skepticism is the chastity of the intellect—not to be surrendered too easily to the first comer.") Let us remember, though, that no procedure in any profession can be backed by a 100% guarantee. No profession can advance its technique and its service to its clients without thoughtful re-evaluation of policies and procedures and careful experimentation and research.

Adoption workers are familiar with the difficulties in the exchange of information. Perhaps another adoption agency is experimenting in this way, but since we have no knowledge of this our findings are arrived at independently.

No claim to statistical validation of findings is made. On the other hand, the workers involved in this experiment brought to it the knowledge gained through the placement in the last five years of 653 children—knowledge not specifically pertinent but basic to the ability to operate under our hypothesis.

Another observation which, though not unique, reinforced us is that many natural children are overplaced based on the natural endowments and achievements of the parents and many natural children are not properly placed, by agency standards, with their siblings either!

Our agency had two sets of adoptive parents who were "superior" families. That is, they had high cultural, educational, social and financial status in the community. Both sets were well educated: one was a professional man, the other a business man. Both families were outstanding in a far more important way to our agency: there would be no demands to achieve placed on an adopted child; there would be the love and stimulation of good parents, but no pre-determined goals.

With these two families we deliberately

"overplaced" by conventional matching procedures four children.

Family #1 had indicated no sex preference, and the first child placed with them was a 3-month-old girl. This baby's mother had been in numerous institutions and boarding homes until the age of 5, when she was placed for adoption. Her adoptive father was dead; her adoptive mother had no information on her background other than that she was illegitimate and on psychological tests was in the average range. The mother was suitably placed as a senior in high school at the time of conception. She had a poor relationship with her adoptive mother, and in her fantasies saw the alleged father of her child as a mother figure. She was an emotionally deprived person with marked oral needs, she had a strong superego and the consulting psychiatrist felt she was of average intelligence.

The alleged father, 40, was married and had children. He had limited education and an unimpressive work record.

There have been two psychological tests on the child. One at 2.8 months, the Cattell Infant Intelligence Scale, showed the child to be developing at a slightly accelerated rate of development in a good pre-adoptive study home. The second, at 3 years of age, indicated that the child was of far better than average intellectual development. Her verbal proficiency was excellent in terms of vocabulary and she was able to handle verbal abstract material in the manner of the average 4-year-old, but her memory span was more nearly average. Her perception of spatial relations was likewise not much better than average. She exhibited no difficulties in motor coordination insofar as observable. On the Binet she attained a mental age of 3.7 months and an IQ of 119, which would indicate that she is functioning on a superior intellectual

Infant Adoptive Placements

LATIMER

level. The psychologist said the second test results were not significantly deviant from those of the first test, though they seemed more nearly to reflect the child's potential.

On the Vineland Social Maturity Scale this child, in terms of self-help, social adaptivity and independence, scored at the 4.8-year level. Therefore, the psychologist felt the test results suggested she was exceptionally mature for her age.

The second baby, a boy, was the child of a 17-year-old girl who was failing two subjects in her junior year in high school when she withdrew because of pregnancy. Her background was not unusual; her father was dead; her mother had an unskilled job. A sibling had completed high school. When five years old and again at 11 the girl had had psychological tests which revealed average mental ability.

The alleged father of her child—about whom she was reticent to talk, almost to the point of denying sexual contact—was two years older than she. He was a high school graduate and in the service. She knew nothing else about his history. The girl apparently did considerable fantasizing about him as well as about her popularity with boys and girls. She was essentially an immature, rather withdrawn, young girl.

The baby had a great deal of physical difficulty which continued for several months after placement in the adoptive home, which occurred at six weeks of age.

He has had two psychological tests. The first at 7.8 months utilized the Cattell Infant Intelligence Scale and revealed that the child was developing at a slightly accelerated rate.

The second, at 21.6 months, found the child expressing both shyness and dependency upon the adoptive mother. Measured by the Vineland Scale he was in many respects more mature than most children his age. His verbal development seemed com-

parable to that of most 2-year-olds in that he combined words involving two ideas. He was as goal-oriented as most 2-year-olds, and as capable of retaining visual images after 10 seconds. His ability to identify three-dimensional objects was also at this level. His vocabulary was more nearly average insofar as was observable in the testing situation.

The test results indicated that this child was not functioning in any remarkable way different from that during the first test.

Family #2 had also indicated no sex preference and their first baby was a girl, placed at three months. The baby's mother, 28, was referred to us by the alleged father ten days before she was due to deliver. She had rejected pregnancy, had had no prenatal care, had no clothes for baby, etc. She had quit school at the 9th grade. None of her three siblings had finished high school. She had always had poor paying, unskilled jobs.

The alleged father, in his middle 40's, acted responsibly toward both the mother and the agency. He was a high school graduate with a stable work record on semi-skilled jobs. His numerous siblings also were stable on the job and were skilled craftsmen.

The baby was first tested at 2.2 months on the Cattell Infant Intelligence Scale and functioned at a slightly accelerated rate in a good pre-adoptive study home. The second test was at 3 years, 3 months. In such respects as cooperating with adult figures the child's behavior was comparable to that of a slightly older child. Her overall social adaptivity on the Vineland Social Maturity Scale was that of a child 3.4 years. A social quotient of 105 could be computed.

When seen by the psychologist the child exhibited an unusual amount of self-confidence and self-acceptance. She related re-

markably well to the examiner in an unfamiliar setting, and was able to accept her inability to perform certain tasks or problems to her own satisfaction.

The psychologist described her as a "merry little girl" who was, most of the time, responsive and eager to please. When she grew bored she became haphazard or gave joking, irrelevant responses. Her picture vocabulary was comparable to that of the average 5-year-old, according to Binet standards. Her dexterity was average but her perception of spatial relations was significantly better than average. She handled abstract data fairly well for a child her age, but experienced some difficulty in rapid shift of attention. Her ability to handle analogies was comparable to that of the average 4-year-old.

The psychologist pointed out that this child would certainly be ready to go to school at the appropriate age and it could be reasonably speculated that the quality of her school work would be above average. On the Binet she attained a mental age of 3 years, 8 months, and an IQ of 113. Her verbal skills suggested potentials for a slightly higher level of functioning.

The second child, a boy, was placed when he was 10 days old. He was born to a 19-year-old mother. At the age of 11 she had been removed by an out-of-state social agency from her parents' home, which had been considered unfit. She had left school at 15 when in the 9th grade. She had had some poor paying unskilled jobs. She apparently had average intelligence. Her inadequate knowledge of her parents provided little history and she had no recent contact with her siblings, whose intelligence could be presumed, she thought, to be average, though none had gone beyond the 9th grade.

The alleged father of her child, a high school graduate, was a garage mechanic; he

was 22. His younger siblings were properly placed in school.

This mother had strong maternal feelings—named her baby, etc.—but had no ambivalence regarding adoption.

Her baby was tested first at 6.0 months on the Cattell Infant Intelligence Scale. At that time his rate of mental development was accelerated. The second test was at 2 years of age. Results on the Vineland Scale suggested that the child was functioning at a superior level as to feeding habits, toileting, dressing and social responsibility. His proficiency and adaptivity in these areas were comparable to those of a child of 2.4 years. On the basis of this test a social quotient of 121 could be computed.

This child, too, related remarkably well to the examiner in an unfamiliar setting and accepted himself at the level where he was. He displayed excellent language facility for age. He was able to identify pictorially presented objects in the manner of the average 4-year-old. He was an active boy who as he worked voluntarily gave names to materials. When requested to build blocks in a certain way this 2-year-old not only accomplished the task but told the examiner that it was a bridge. He exhibited the motor coordination and fine finger dexterity of a child six months older. While he dealt with spatial relations in an appropriate fashion, he was not as precocious in this area as in others. His memory for verbal and non-verbal data was excellent. He had no difficulty in associating objects with their function.

Despite some fatigue and distractibility, this test performance indicated that the child's intellectual level of functioning was superior. His test performance yielded an IQ of 138 and a mental age of 2.9 years. The psychologist stated that apparently in his adoptive placement this boy had been able to realize his potentials.

Infant Adoptive Placements

LATIMER

Here we have, then, four children whose backgrounds were certainly "average" who with the love, acceptance, security and stimulation of "superior" adoptive parents are progressing socially, intellectually and apparently in that vague area of emotional stability at a rate more comparable to that of their adoptive than their natural parents.

One cannot prove nor possibly even allege that had we placed these children in a more "average" home their developmental history would have been different. Nevertheless, it seems safe to say that placement in homes *above* the level we would have chosen had we "matched" backgrounds has afforded these children the fuller development of their potentials. Isn't life going to be richer for them as a result of these placements?

Properly motivated, the "average"-heredity child making full use of his endowment can surpass others better endowed but without proper stimulation. As Albert Einstein said, "... behind every achievement exists the motivation which is at the foundation of it and which in turn is strengthened and nourished by the accomplishment of the undertaking".⁵

So, too, H. E. Walter says, "... a hereditary character of any sort is not an entity which is handed down from one generation to another, but is rather a capacity in an organism to react in a certain definite way to the constellation of environmental factors in which it finds itself. It cannot be emphasized too often that inheritance does not depend alone upon the hereditary determiners in the germ plasm, but that the environment is indispensable. . . ." ⁶

Later, Walter mentions the sleeping giant of possibility in everyone.⁷

Philosophically, too, one can reflect on the rights of the adoptable infant. Has he not the right to the very best home we can provide? Isn't that the reason for our care-

ful home studies? But how do we define "best"? The usual standards and values are important. Is that enough? If we accept our tentative hypothesis: "The limitations of heredity are essentially limitations only to the degree they are not overcome by appropriate emotional, intellectual and social stimulation and satisfaction," our answer must be no.

Actually our hypothesis is not as heretical as first appears. Already, as good practice, we provide for our infants "better" homes in many ways than the natural parents could offer.

We think nothing, for example, of markedly raising the physical environment of our babies through adoptive placement. We know, too, that we provide many of today's babies, whose natural mothers are often teenagers, with older, more mature mothers. Comparative studies by our agency, in summary, of natural and adoptive parents indicate considerable differential in employment, education, income and stability.

It is primarily in the area of intellectual prognosis that we become timid. Any "experiment" in human relations is fraught with difficulty because of the emotions involved and because of the problem of evaluation. But how else can we learn?

We undertook another "experiment" with 17-month-old Tony. Here we were faced with conflicting and discouraging social, medical and psychological diagnoses. We had no family at the level we usually would have considered suitable and therefore a

⁵ Albert Einstein, "Some Thoughts Concerning Education," *School and Society*, 44 (1936), 590.

⁶ H. E. Walter, *Genetics*, 4th ed. (New York, Macmillan Co., 1938), 7.

⁷ *Op. cit.*, 337.

good match, who could meet this child's peculiar emotional situation.

Tony was born to a 23-year-old mother. She had attended school until her 16th year, when in the 10th grade. She was an unskilled worker of estimated average intelligence. There was nothing unusual in the full maternal history available to the agency. The educational achievement of her siblings was average for their age. Of the two of sufficient age to finish high school, one had done so.

The paternal history was also available in detail and was also "average." Tony's father, a high school graduate, had a good work record. His siblings were also high school graduates.

There was nothing unusual in the actual birth history. Labor lasted four hours with no foetal distress and Tony's reactions were spontaneous with no resuscitation needed.

Tony's mother, however, completely rejected this pregnancy and this child. She identified Tony with his now-hated father, made no plans for names, and always referred to the baby as "it." Both before and after Tony's birth she dreamed that there were many people around her and that she was always pushing the baby away from her. After Tony's birth, it was felt that the excessive bleeding and complaints of after-pains were psychogenic in origin.

Four days after birth, Tony was placed in a pre-adoptive study home and eight days later he was hospitalized for four days because of jaundice. From the beginning of the boarding home placement, however, the boarding mother and the social worker shared the feeling that this was a very unresponsive child who seemed to be developing slowly mentally.

By four months the boarding mother and the neighborhood general practitioner were thinking the baby was deaf and our pediatrician accepted tentatively that there

might be some degree of hearing loss. By the time Tony was a year old, however, a specialist had determined that the structure of the ear was normal.

In the meantime, when Tony was 2.9 months of age the agency psychologist found the baby's rate of mental development to be retarded and said he was not a good candidate for adoption. A re-test at 4.3 months resulted in the statement that his "rate of mental development is only slightly retarded and potentially low average." At 10.3 months the low-average rate was maintained with a potential of average.

As time passed, however, Tony was practically mute and such sounds as he made were guttural and not understandable. He did not respond normally to adults, children or infants. He did not appear frightened, but there was a "distance" and preoccupation about him that made him noticeably different. By now, too, he had developed strabismus.

The next step, of course, was psychiatric diagnosis. A reputable child psychiatrist saw Tony when he was 16½ months old. He felt Tony might give the impression of normalcy if one looked at him fleetingly. He said, however, that Tony's facial expression was quite blank, displaying very little vitality in expression. He showed no curiosity or interest in people or things. He made not one sound for 45 minutes and then a few meaningless ones. He showed little emotion and when given a cookie which he began to eat did not even cry when the cookie was taken abruptly from his hand.

His motor patterns were not considered good. He moved slowly and used his hands in a clumsy, immature way.

In summary, the psychiatrist felt there was nothing in Tony's total behavior really normal for his age. The psychiatrist classified him as a severely retarded child who

Infant Adoptive Placements

LATIMER

in his opinion would never qualify for legal adoption.

Faced with this total situation, the agency turned to a local physician with whom we had had previous contact through his adoption of a teen-age boy. All the above material was reviewed with this family in full detail and not accepted by them, after Tony visited their home, as final. He was placed on a "trial free home basis" with this family when he was 17 months old.

Almost immediately a remarkable change took place. With this exceptionally understanding, loving family Tony developed quickly. Within two weeks he was making understandable sounds for kitty, dog, man, dad and the equivalents of the other children's given names. In a few more weeks he related easily to visiting children and adults, ate at the table with family and visitors, and was acting in other ways in a "normal-average" way.

A children's eye specialist diagnosed his condition as a high degree of compound hypermetropia (farsightedness), astigmatism of both eyes and esophoria (inward deviation of an eye), and glasses were prescribed.

After nine months in this home Tony was seen by a neutral psychologist, the chief psychologist of a well-established psychiatric clinic. Her report, summarized, was: "Tony is an attractive and engaging child. Not large, he nevertheless looks healthy. His bespectacled appearance and his animation suggest a lively little gnome. In the family group the child responded rather naturally to the presence of a stranger, and was soon willing to show his toys to the psychologist and to talk about them to her. His adaptation to the test situation was good. He was not overly active, overly distractible, or difficult to direct. He responded with interest to the test materials and showed a good degree of persistence. Sometimes absorption in a particular object or activity

seemed to prevent him from responding maximally to other parts of the test—a behavior not unusual in young children.

"Tony's performance on the Revised Binet Scale, Form L, when scored very objectively, implies intelligence approximating the lower limits of the normal range. He uses his hands well and perseveres in motor activities. His speech is reasonably good, in that he combines words into rudimentary sentences; most, but not all of it, was intelligible. He has a reasonably good knowledge of common objects and their uses.

"The Vineland Social Maturity Scale, on which observational data was supplemented by information from the parents, suggests that in areas of self-help, locomotion, communication, etc., the child functions within the normal range.

"The results of the study, when viewed in consideration with the history, must certainly be considered encouraging. In any one test situation, a subject, particularly a young child, whose responses are frequently largely self-initiated, may not function at his optimum. Tony has certainly shown marked improvement during his relatively brief life span, particularly the last nine months, and there is no reason to believe that he will not continue to improve.

"The adoptive home has obviously made a momentous contribution to Tony's social, emotional and mental growth. He has found love, acceptance and environmental experiences which have enabled him to become a happy, secure and responsive child, as well as one who can now demonstrate on psychological tests a performance approximating the normal."

The change in this child in this adoptive home, fully substantiated by objective evidence, is dramatic, startling and even tragic.

Tragic? Yes, because one can think of the many other such children penalized by the

cautious conservatism of social workers and deprived of the "best home" because we lack the courage to take risks with the right adoptive families, which we also usually have to make a special effort to find. The criterion of what makes adoptive families "right" is, of course, a different subject. That the families have to be carefully studied and especially chosen is obvious.

Tony's adoptive family, highly educated on both sides with own children of superior intellectual endowment, never doubted the powerful influence of love, security and proper attention to physical problems in helping this child to normalcy.

Social workers are the greatest advocates of working with reality factors. Are we, however, always sure what is reality? Realistically, what do we scientifically know for certain about predicting adult potential from heredity, early physical development and infant psychological tests? Isn't reality uncertainty and unpredictability about the future?

Dr. William M. Fischbach, a physician who is also an adoptive father, points out that there is a degree of validity in all these approaches, but he feels strongly that the intangible something which is somehow brought out in interpersonal relationships must not be overlooked:

"The human will
That force unseen
Can hew its way to any goal
Though walls of granite intervene."

Or, stated differently, "Through aspiration to the stars."

This philosophical approach to the whole

matter is emphasized again for us in Gilbert Highet's *Man's Unconquerable Mind*. Highet says the normal man "leaves large areas, perhaps two-thirds, of his brain dormant."⁸

No one can read this highly stimulating book, with its emphasis on the individual's unused reservoir of intellectual and other strengths, without wondering again about our theories of matching. Example after example of individuals who have outsoared their origins, of the limitless treasure of individual ability, of the inexhaustible power of the mind if subjected to challenge and stimulus, are given.

Social workers want to be as scientific as possible, but most of us know there is a plus in our relationships to our clients. Whether we call it Grace—someone's love, a gift freely given, and response to a gift freely given⁹—or by another name it is a factor in our practice. Similarly, it is a factor in relationships within an adoptive family.

In dealing with human beings we are always aware of the impossibility of our knowing all the answers. We feel deeply our obligation in adoption to do the very best we can for our clients—for the natural parents who trust us with their baby, for the adoptive parents who rely on our professional competence, and most of all for our primary responsibility, the baby. Yet we all know it is impossible to guarantee results. We have always maintained that natural families take what may come and face disappointments with their children. It seems grossly unfair to our fine adoptive families not to believe that they too can love a child for himself and can accept him as he develops. We firmly believe, based on considerable experience with adoptive families, that they need not be so protected. Actually, of course, we tend to believe that our averagely endowed child will do well in

⁸ Gilbert Highet, *Man's Unconquerable Mind* (New York, Columbia University Press, 1954), p. 69.

⁹ St. Thomas Aquinas, *Nature and Grace*, translated and edited by A. M. Fairweather (Philadelphia, Westminster Press, 1954), p. 157.

Infant Adoptive Placements

LATIMER

a "superior" home and therefore that the risk of disappointment is not great. Nevertheless, we feel it is a calculated risk and one that we should more frequently take.

We are not advocating the universal adoption of this "over placement" technique. Not at all. Just as the general policy of early placement of infants in adoptive homes is modified many, many times within an agency based on social, legal or medical considerations, so any such policy of "over placement" must be used with discrimination and caution after a careful consideration of all the factors involved.¹⁰

But it *should* be used. Not to do so is to

deny to many infants those tangible and intangible opportunities and advantages which democracy offers to them as their birthright and heritage.

The obligation of this reality should stimulate us beyond the human frailty of our personal fears and timidity. It should give us the courage to aspire to greater accomplishments for the children for whom we have been charged with such a tremendous legal, social and moral responsibility.

¹⁰ See John R. Wittenborn, *The Placement of Adoptive Children* (Springfield, Ill., Charles C Thomas, 1957) for additional evidence in support of this theory.

Parent and child

If a child is with his parents at the time of the impact of a disaster, his reactions to this event may be greatly influenced by his parents' behavior. If the immediate response of the parent was such as to offer support to the child, this response indicated a fairly reliable supportive parent in whom the child could place his confidence. If the parent's response was a hysterical demand for help, then the child-parent relationship was seen to be reliably unreliable in day-to-day affairs.—Excerpted with the permission of the Institute of Living (Hartford, Conn.) from a review of "Patterns of Parent-Child Interaction in a Disaster" by Earle Silber, Stewart E. Perry and Donald A. Bloch, *Psychiatry*, 21 (May 1958), 159-67, in the *Digest of Neurology and Psychiatry*, 26 (August 1958), 351.

MARVIN I. SHAPIRO, M.D.

Psychiatric examination of the child

The psychiatric examination of a child may superficially bear very little resemblance to the psychiatric examination of an adult patient. Nonetheless, the interview with the child—although it may be conducted on the floor during a game of jacks or with the patient sitting on the examiner's lap sobbing over a broken toy—remains essentially a reapplication of basic principles of interviewing techniques in a different setting.

In developing an understanding of the emotional aspects of a child's difficulties, the pediatrician, general practitioner, psychiatrist or other worker may at first feel uncertain in his approach to the child. Many unexpected, disconcerting situations

develop, and it is often not clear what to look for during the contact with the child. Frequently all that is obtained from the examination is an impressionistic recollection of some outstanding trait or performance rather than a well-considered appraisal of the child and the problem. The mental status examination is useful in evaluating the personality of the adult patient. There has been no comparable standardized guide, however, for the psychiatric examination of the child.

The purpose of this communication is to present a form for the diagnostic evaluation of a child which organizes the many inferences that may be drawn from interaction with the child. Space limitation prevents a discussion of the many specific contributions which have been made on this subject, but special mention should be

Dr. Shapiro is assistant professor of child psychiatry at the Pittsburgh Child Guidance Center.

The Psychiatric Examination

SHAPIRO

made of the monograph titled *Diagnostic Process in Child Psychiatry* (1). The writings of Erikson (2), Sullivan (3), A. Freud (4), Lippman (5), Gill (6), Witmer (7) and Nixon (8) have also been drawn upon freely.

BACKGROUND

Before taking up the examination itself, it will be useful to review some general concepts that help put the diagnostic activity into proper perspective in the process of helping a child by means of psychiatric intervention.

The study of a child's difficulties must include an evaluation of the familial and environmental factors. In this paper, however, the focus is upon the child himself. It is helpful to keep in mind that while the doctor is going about his work the child is also busily appraising the doctor, and that the conclusions formed by the child will enter into the clinical behavior the doctor is observing.

The psychiatric examination differs from the medical or laboratory examination in that psychiatric examination, diagnosis and treatment go on simultaneously and cannot be separated from one another. Like a juggler, the examiner needs to coordinate the many aspects of his relation to the child. The emphasis in this outline will be upon organizing the information originating from the interview in such a way as to enable the doctor to act most effectively in behalf of the child and his problem. It is planned to consider what takes place during the psychiatric examination of a child, what is to be observed and tested. The problem of *how* to conduct the examination is outside the scope of this paper, as such skills are best gained under supervision and no fixed procedure for this can be easily described.

Prior to the examination, the doctor

should have some general plans to help him organize the raw data of the child's behavior. He should have some ideas, obtained from a previous contact with the parents, as to what to expect. The purpose of the examination is to determine the nature of the problem, whether or not treatment is indicated and if so, who is to receive it—the child, the parents or both. An effort is made to categorize the problem in the classification system used in general psychiatry, and the doctor accumulates the evidence that permits him to diagnose the presence of organic brain damage, a psychotic disorder, a psychoneurosis, etc. When psychopathology is found, the doctor evaluates its severity, seeking to clarify whether the disturbance is a situational response and transitory or whether it has become part of the child's personality. The examiner's estimate of the treatability of the disturbance or of the child's capacity to change is just as important as the recognition of psychopathology.

With this as our orientation, we can turn to a consideration of the psychiatric examination. It is to be anticipated that the items suggested in this study are not to be used during the interview in the same order in which they appear in the outline. Rather, the form may be useful as a mental check list of the various elements which enter into the examination.

IDENTIFICATION

This is an orienting statement which forms the background and reason for the clinical evaluation of the child. The subsequent interview will attempt to answer the question implied here. Where the parent has a host of complaints regarding the child, it is important to identify the primary difficulty which is the most disturbing to the parent.

The outline of the psychiatric examination of the child

IDENTIFICATION

Name, age, sex, religion, color, ordinal position, reason for referral, who referred, first or second examination, etc.

APPEARANCE

Build, facial expression, clothing, health, defects in hearing, vision, etc., personality traits, mannerisms.

INTERPERSONAL RELATIONS

Interaction with parent—waiting room, degree and type of anxiety upon separation, response to reassurance, reaction upon rejoining parent.

Interaction with examiner—attitude: arrogant, suspicious, cooperative, etc.; capacity to relate; type of relation: trusting, controlling, erotic, etc.; role taken and role assigned to doctor; feeling aroused in reaction to patient; beginning compared to end of hour; first interview as compared to last.

CAPACITIES

Intelligence—estimated level: knowledge, imagination, grasp of situation; potential capacity.

Affects—mobility, appropriateness, predominant moods, shame, anger, depression, anxiety, etc., shifts in tension, somatic expressions as sweating, blushing.

Motor—coordination, gait, muscularity, use of hands, body, activity pattern, inhibited, immature, hyperactive, etc.

Speech—clarity of diction, of ideas, defects, vocabulary, pressure, spontaneity, voice quality, etc.

CONTENT

(Attitudes, feelings, ideas, etc.)

Towards clinic visit—reaction to visit, grasp of purpose, awareness of difficulties, reaction to symptoms, feelings about return visits, participating in planning.

Towards self—Behavior, appearance, body, sex, intellect, worries, fears, preoccupations, etc.

Towards others—parents, siblings, relatives, peers, teachers.

Towards things—pets, hobbies, possessions, money, food, school.

PLAY AND FANTASY

Play—approach to and interest in toys, toys used, mode of play: incorporative, extrusive, intrusive, etc.; manner of play: constructive, disorganized, nurtural, etc.; distractibility, play disruptions, etc.

Fantasy—wishes, dreams, daydreams, fantasies, ambitions.

CLINICAL IMPRESSION

Descriptive—summarize personality structure.

Dynamic—major areas of conflicts, mechanisms of adaptation.

Statistical—use standard nomenclature and code number (9).

PROGNOSIS

Benign, malignant, acute, chronic, with treatment, without treatment.

DISPOSITION

Further diagnostic studies, need for treatment, treatability, psychiatric therapy, environmental control.

TREATMENT

Individual, group, collaborative, consultative; frequency and estimated duration of therapy, goals, family management, countertransference impressions, general approach.

The Psychiatric Examination

SHAPIRO

APPEARANCE

A vivid description of the impression that the child creates helps to establish a mental picture of the kind of child being examined. The items listed make no attempt to exhaust the descriptive possibilities. Some further items could include family resemblances in the facial expression, whether the child appears older or younger than his stated age, details of body care such as bitten nails or unkempt hair. Gross neurological signs such as facial asymmetry, disturbances of gait or nystagmus will suggest further medical investigation. The first few minutes of the interview may be regarded as having a far greater degree of intensity and therefore more significant influence upon the remainder of the interview than any other similar few minutes during the examination. Aichorn (10) has emphasized the importance of the quick impression in the beginning moments of the interview when recognition of the dominant attitude and feelings of the child enable the doctor to respond most appropriately to the child.

INTERPERSONAL RELATIONS

Observation of the child in the waiting room often furnishes valuable clues as to the nature of the parent-child relationship. The physical closeness or apartness of the child and the parent, the attitude of the parent as expressed in voice tone and manner of handling the child, the reaction of the child and the parent to the separation—all these are noted in the first few moments of the study.

As a general procedure, it is preferable to plan for at least two diagnostic interviews. While one may be sufficient (and at another time three or four sessions may be indicated), two interviews permit the examiner to observe the changes in the

child's responses to his visits. A child who remains detached and stolidly defensive in successive interviews presents a different task in the planning of therapy from the one who shows a progressive ability to relax and to relate. The former indicates that the character formation has already become involved and the child will probably require individual therapy regardless of any subsequent alteration in parental attitudes and behavior. In the latter case, the changing nature of the relationship indicates a greater elasticity of the child's personality. This in turn suggests that the attempt to change the parents' attitudes and relationship to the child will be an important part of the treatment plan.

The feelings aroused in the examiner in reaction to the child are another valid source of data. At the descriptive level, a child may appear to be silent and inhibited. Yet one child may be frozen with fright, another rigid with anger, and still a third provocatively teasing. The most sensitive recorder of these different moods remains the emotional response of the examiner.

CAPACITIES

Here is described both the endowment that the child possesses and his ability to use it freely. This includes the enduring assets as well as the outstanding liabilities which are observed in the child. The level of functioning and the degree of stability in maintaining this level form a base line against which future progress or regression can be measured. The manner of functioning that the child demonstrates may suggest the therapeutic approach to be used. One child may be over-intellectualized and need help in relation to isolation of emotional feelings. Another may act impulsively, indicating difficulty in controlling motor activities. Still another may be un-

usually sensitive and shrink from close contacts with people.

The examiner is alert for fluctuations in the level of performance—such as flashes of intelligence, which help in the differential diagnosis of a brain-injured child or a mentally retarded one.

CONTENT

It is helpful to gain some understanding of the child's ideas and feelings about coming to see the doctor. The preparation of the child for the examination should be reviewed beforehand with the parents. It is usually quite revealing to observe the results of preparation, not only in terms of the child's personality but also in terms of the parent-child relationship. There are many possibilities to explore: The child may not have heard what was said to him, or he may have distorted the information, or the parent may have been unable to be direct with the child in this matter.

During the examination the child should be prepared by the examiner for other procedures such as psychological tests, and for future visits. The child's ability or inability to express his feelings about such important figures as his parents helps the examiner to map out the sensitive areas in the child's living experiences. The over-all total response of the child to the new situation throws light upon the character formation and the defenses that the child characteristically uses in meeting life's stresses. The child's appropriate or inappropriate response to the clinic setting furnishes an opportunity for estimating the capacity to adapt.

The doctor needs to be familiar with the series of problems that each child meets in growing up and to evaluate the current difficulties in terms of the successful or unsuccessful integration of these successive

stages of psychosexual development. The individual problem may appear in the form of a currently unrealistic belief about the world or about himself. It may show up as an exaggerated feeling or absence of feeling, or an inability to act, or a preoccupation with one particular activity, or indeed any combination of any or all of these. Once identified, the tendencies should be cautiously tested to see whether it is flexible and reversible or whether it has become isolated from the influences of daily living and part of the character of the child.

Throughout all of his efforts to understand the child, the examiner does not simply probe for factual material but creates the atmosphere which is most favorable for a spontaneous interchange of matters of interest to the child.

PLAY AND FANTASY

The child's fantasy life and play activity offers significant indicators of the unconscious determinants which enter into his behavior. Through these media, as through dreams, the needs and wishes that are too anxiety-provoking to be directly expressed find discharge. A child can be encouraged to share his fantasies by such questions as "If you could make three magic wishes, what would you wish for?" or "What do you want to be when you grow up?" or "What is your favorite program on television?" The doctor can express his interest in hearing about dreams which the child enjoyed and dreams which were frightening to him. This tension-releasing function of fantasy and play is not only of service to our diagnostic purpose, but also indicates the therapeutic openings which can be used in helping the child gradually express his desires and fears more freely.

While the emphasis in this paper has been upon a verbal interchange, at times it

The Psychiatric Examination

SHAPIRO

may be desirable to use play materials such as dolls, clay or pencil and paper to help the child express himself. The experience and personal preference of the examiner will help decide the choice of such aids. A few dolls in a family scene may help the child relate how he feels about an emotionally-charged aspect of his home life. If he shows an interest in drawing pictures he may be asked to tell a story about them. As the child talks, the examiner listens for the particular affect, such as shame or anxiety or anger, which appears as a persistent thread woven into the fabric of the stories and dreams. It is this thread that is so important in understanding the painful feelings against which the child needs to defend himself.

The mode of play item has been adapted from Erikson (2) and refers to the principal way that the child functions or, to put it differently, to his main style of life. For example, the hyperactive child who is unusually curious and prematurely pugnacious, who literally gets into everything, may be using this intrusive form of behavior to express unresolved phallic strivings. Sudden alteration or disintegration of a play activity is carefully noted as a sign of increasing tension, and the examiner relates the disruption in play to what has just preceded it.

CLINICAL IMPRESSION

These separate diagnostic impressions summarize the significant findings which have emerged from the examination. The child is described as to what type of a person he is and how he tends to deal with his difficulties. From the review of his observation and participation, the doctor also infers what the sources of the difficulties are. The value of a statistical diagnosis lies more in the direction of recording information about

similar clinical problems in order to gain a broader base for our understanding, rather than of being of immediate clinical use with the child.

The diagnosis of psychopathology in the child is less definitive than the diagnosis of psychopathology found in the adult. The immaturity of the child and the flexibility of his defenses allow for a shifting of patterns of response to stress. An understanding of this prepares the doctor for the discrepancies he will often meet where the child's reported problem is so different from what is actually observed clinically. The interview is part of a total dynamic interplay of forces, and the relatively isolated sample of behavior which is noted will limit the scope of conclusions to be made. Still, a working hypothesis that allows practical, realistic action to be taken can almost always be synthesized from the various data that have been accumulated up to this point.

PROGNOSIS

A projected course of events may be considered in terms of a historical review of the problem as it has developed up to the present time. While the doctor is unable to predict every adaptive stress that the child will face, he may be able to anticipate some. For instance, it may be expected that an 8-year-old patient who shows a potentially psychotic disorder will have considerable difficulty in handling the problems of adolescence, and perhaps may be unable to manage them with success. Social and economic realities, the stability of the family unit, the intelligence and concern of the parents are some of the significant factors to be weighed in the prognosis. To these the doctor adds his judgment of the malignant or benign quality of the child's difficulty as it appeared during the examination.

DISPOSITION

Here the doctor recommends the next step to be taken in the management of the child's problem. The primary decision to be made is in regard to the treatability within the setting where the child is examined. In a clinic where different workers may see the child and his parents, the assignment of the collaborating therapist is considered. Recommendations for further medical studies are also made when necessary.

TREATMENT

Once the need for and the feasibility of psychotherapy has been established, further details of treatment are to be considered. The decision of who is to receive treatment—the child, the parent or both—is important. The type and frequency of therapy—whether supportive or uncovering, individual or group—should be considered. The goal of therapy and the problems that might be anticipated should be recorded as well. These matters are not regarded as fixed and unalterable but are to be changed when indicated.

DISCUSSION

While the technical problems of interviewing do not lend themselves readily to diactic-analysis, it may be fruitful to reflect upon some of the special situations which often arise in work with children.

Recognizing that the child often comes unwillingly, the doctor is prepared to meet and help his patient, who is frequently most uncooperative. If possible, the doctor sees the child alone in order to observe how he handles himself when he is on his own. With some children, however, the separation may stir up such an overwhelming amount of anxiety as to threaten to disrupt self-control. In these situations the parent is asked to accompany the child until a

tolerance for the separation is developed. The principle here is the same as is found in all fields of medicine: The doctor himself should do no harm and must not introduce a new traumatic experience into the problem.

Should the child angrily refuse to accompany the doctor to his office, the doctor responds as appropriately as possible to each specific situation. He accepts the child's anger as an expression of anxiety over the examination. At the same time, he helps the child avoid feelings of shame which could arise afterwards if infantile, regressive behavior were allowed to control the situation. This is accomplished by the firm insistence that the examination be carried out. By his own direct participation the child has the opportunity to see that his fears about it were unrealistic. In the case of a pre-school child the examiner may simply pick up the child in the waiting room and carry him into the office. This, however, would be humiliating for a child of school age, who is no longer accustomed to such physical control by parent-figures; here the doctor would be acting more appropriately to take the child firmly by the arm and lead him into the office. This illustrates an important point, namely, that the doctor needs to adapt his own behavior and expectations concerning the child's performances to the age and personality of each patient he sees. The needs and problems of the pre-school toddler are different from those of the adolescent, and each requires a modification in the clinical approach used by the doctor.

The question of the use of physical force is often a source of personal difficulty in professional work with children. The doctor is ready to act whenever necessary to keep the situation within limits of comfort and safety. If verbal controls do not suffice, then physical control may be required. The

The Psychiatric Examination

SHAPIRO

confident readiness and unambivalence of the doctor is actually reassuring to the child, who may have anxiety over his own lack of self-control.

The real dependence of the child upon adults requires that the doctor be aware of his dual role. He is both a parent-surrogate as well as a physician and cannot remain completely impersonal in his relation to the child. In an interview with an adult patient who breaks down and starts to cry, the doctor waits until he has regained composure. In the case of a young child, however, the doctor does not remain so detached, but offers the child his own handkerchief or draws him close for physical comforting. In working with the pre-school child, the physical nearness of the examiner may be used to help establish the relationship. It is often of value for the examiner to pick up a child who is sitting alone and feeling very alone and hold him on his lap. If a child remains absolutely silent in the face of the examiner's attempts to relate to him, it may be helpful to gently take the child's pulse rate. A racing pulse suggests that the child is struggling to control inner tension, while a relatively normal pulse rate indicates a greater degree of ego participation in the resistance.

In this fashion the diagnostic process demands active participation by the doctor so that bits of behavior can be properly evaluated. A careful consideration of the physiological factors, psychosexual development and cultural background is necessary for the analysis of any one clinical problem.

Since the major portion of this paper has been centered around the facets of examination and diagnosis, a reconsideration of therapy during the interview should be added to restore balance in this matter of helping a child in difficulty. Since the child is most often brought to the clinic because of the parents' concern, his initial position

is a passive one. The symptomatology for which the parents are seeking help may in no way correspond to the worries or concerns that the child has about himself. Part of the purpose of the visit, therefore, from a therapeutic point of view, is to interpret the interview in terms of what the child himself wants or is worried about or would like to be helped with. We seek, at all times, to engage the child's own participation in the therapeutic process. If this concern with the child's own preoccupation is lacking, the examination will tend to remain an objective description of the child and his functioning, and the child's own emotional investment will be minimal. Ideally, his contact with the doctor should be a constructive experience in living for the child. It should expand his trust of adults and begin to supply the help he needs.

BIBLIOGRAPHY

1. Group for the Advancement of Psychiatry, *The Diagnostic Process in Child Psychiatry*. Report 38, August 1957.
2. Erikson, Erik H., *Childhood and Society*. New York, W. W. Norton, 1950.
3. Sullivan, Harry Stack, *The Psychiatric Interview*. New York, W. W. Norton, 1954.
4. Freud, Anna, *The Psychoanalytic Treatment of Children*, London, Imago, 1946.
5. Lippman, Hyman, *Treatment of the Child in Emotional Conflict*. New York, McGraw-Hill, 1956.
6. Gill, Merton, *The Initial Interview in Psychiatric Practice*. New York, New York University Press, 1954.
7. Witmer, H. L., *Psychiatric Interviews with Children*. New York, Commonwealth Fund, 1946.
8. Nixon, Norman, personal communication.
9. *Diagnostic and Statistical Manual: Mental Disorders*. Washington, American Psychiatric Association, 1952.
10. Aichorn, August, *Wayward Youth*. New York, Viking Press, 1935.

ISRAEL W. CHARNY, Ph.D.

Communication between psychotherapist and teacher in treatment of the severely disturbed child

Johnny is a patient in Rochester's "EE" unit (for the "emotionally exceptional"), an experimental class for 10 severely disturbed boys. It is staffed by a full-time teacher and a full-time group worker, and aims at providing a therapeutic experience in everyday living and learning for these children. Each patient is also seen regularly in psychotherapy, usually by the clinical psychologist or psychiatric social worker attached directly to the unit. In some cases, however, the children are seen in treatment by other clinicians not immediately connected with the unit. Such was the case with Johnny who was in treatment with a

psychotherapist at a local community clinic. For some months, teacher and group worker had been complaining that this arrangement left them with too little understanding of Johnny's behavior, and that they felt themselves confused in their efforts to work with this child—whereas they had regularly scheduled meetings with the therapists of the other children to clarify their ongoing problems. Now the point had come where teacher and group worker were very much at an impasse and felt that they must insistently invite Johnny's therapist to a conference around their problems with the child. Johnny's therapist was obviously unhappy over this invitation at first, but after much prodding the conference was scheduled.

The group worker opened the conference with the remark that he and the teacher would like to understand more of Johnny's

At the time Dr. Charny wrote this paper he was with the Board of Education of Rochester, N. Y. Since then he has joined the staff of the Oakbourne Hospital in West Chester, Pa., as chief clinical psychologist.

Psychotherapist and Teacher

CHARNY

problems in a way which would help them in their everyday work with the boy. On hearing this, the therapist—obviously a reluctant hostage at this meeting to begin with—openly expressed his reluctance to go into the full dynamic picture of his patient, and did so in a manner that aroused much resentment from the teacher and group worker. There followed a fairly direct exchange of verbal blows until finally the therapist agreed, though in a somewhat angry and condescending way, to sketch Johnny's progress in treatment to date. This he did, very lucidly in fact, though he confined himself largely to presenting a broad overview of Johnny's reactions to the treatment situation.

The teacher and group worker then proceeded to pose for the therapist their specific problems. They pointed out, for example, that Johnny had taken to climbing up on the storage closet in the classroom and stayed there, moping, for some time; they were unsure whether Johnny was ready for them to make vigorous attempts at drawing him out from this withdrawal or whether he should be left alone for the most part at this stage of treatment. Another typical situation which concerned them, they continued, was that even when Johnny remained in the physical presence of the other children he characteristically involved himself so intently in clay modeling that he was virtually left out of the group psychologically anyway. Here too they needed to know whether to encourage him to leave his modeling and enter into a more aggressive interaction with his classmates or to leave him to his self-expression in clay. Still another question which was posed for the therapist was whether Johnny should be encouraged to travel to and from school on his own as some of the other patients had recently begun doing, or should continue to be transported by the school

bus. Finally, the teacher felt that he needed help in deciding whether the time had come to introduce a concerted program of reading instruction for Johnny, or was he still too engrossed in his defensive consolidation to tackle this step forward?

To these well-formulated questions, the therapist's initial reaction was derisive and, not insignificantly of course, self-deprecating. In effect, he took the position that a therapist doesn't know the answers to such specific questions. "How should I know?" he insisted, as if his work with the child bore no implications for the reality of the child's life outside of the treatment office. In the dispute that followed, the therapist concluded angrily, "We (therapists) can't be God!"

Happily, with some gentle and well-meant give-and-take on both sides, the discussion was able to proceed to a consideration of the specific questions posed by teacher and group worker, and a meaningful treatment plan did in fact finally emerge. Specifically, it was agreed that this did seem an appropriate time to encourage Johnny actively away from his withdrawal to the storage closet as well as from his self-protective engrossment in clay modeling. It was also felt that Johnny should be urged at this point to undertake traveling to and from school on his own, and that the teacher might feel free at this time to initiate a more emphatic program of reading instruction for the youngster.

The discussion was so successful, in fact (in part perhaps because of the very tension which had been generated earlier in the meeting and which now needed to be resolved), that a still more ambitious plan emerged from these considerations: They would work towards a trial placement for Johnny of several hours a day in one of the school's regular grades. It was agreed that if Johnny succeeded in this trial place-

ment he might be discharged entirely from the special "EE" unit the following year and returned full-time to a normal grade while he continued in treatment at the downtown clinic.

Now, a year later, this plan has taken effect, and Johnny continues to make significant strides towards recovery.

THE ADVANTAGES OF COMMUNICATION BETWEEN PSYCHOTHERAPIST AND TEACHER

It has often been observed that patients are in treatment 24 hours a day and not merely for the one hour or so that they spend with their therapist, even when the treatment contacts are restricted to one or two hours a week. With many patients, of course, including children, the therapist need not concern himself very much with the reality figures in the patients' life outside his office. Usually this is the case with patients whose ego defenses are sufficiently intact so that they are able to swim along relatively successfully with the mainstream of their community—whatever the toll they pay in personal anguish or inhibition within themselves. Ultimately, the therapist knows, a successful working through of the patient-therapist relationship in the treatment situation itself will free the patient to more rewarding interpersonal relationships and the enjoyment of greater successes in his everyday life. The patient's real life is brought into the treatment situation for analysis and working through, but the therapist's protection and his direction of the treatment process need not be extended to the patient's ongoing activities outside.

There are other patients with whom such a psychotherapeutic approach is not desirable, let alone sufficient. The psychotic adult, for example, needs the protection and therapeutic direction of a hospital community to maintain and strengthen him

even as more focused psychotherapeutic efforts may be initiated. The physically handicapped, the alcoholic and certain types of character disorders are other examples where "environmental manipulation" and "therapeutic communities" may be indicated. Children, whose tender egos are still very much in development above and beyond the inroads of their illness on their effectiveness in everyday life, much more frequently require a more encompassing treatment program.

Outstanding in this respect is the desirability of involving the child's parents in the treatment process, since therapeutic gains with the child himself will often be short-circuited unless the parents too are able to change along with him. Sometimes this is impossible, or the child's disturbance is already so severe that he cannot be helped in his natural life-setting alone. The continued growth of residential treatment centers for children in recent years is in answer to such needs. These centers are the ultimate in a broadened concept of treatment extending to the child's total life situation.

Even outside a total treatment setting, however, there are many instances where the child's progress and treatment may be accelerated or even depend largely on well-planned "corrective emotional experiences" in his daily life. Rochester's experimental "EE" unit, for example, is an attempt at a halfway point between the total residential treatment setting and the treatment of the child in the normal community in that the child's school hours are spent in a flexible treatment setting designed to provide him with a proving ground for his newly acquired strengths from psychotherapy and to serve as a stimulus to the more focused individual psychotherapeutic process. Such a program is necessarily expensive and limited to few patients, of course.

There are still other situations where in-

Psychotherapist and Teacher

CHARNY

dividual psychotherapy is not available to the disturbed child, but where efforts are made to provide a therapeutic group experience which will hopefully help him at least to modify some of his more exaggerated symptoms. Louis Hay has described, for example, the New York City plan for classes for disturbed children where the clinician functions as a coordinator and resource person for the teachers, the teachers being the "only trained social representatives who are in a position to contribute toward the better adjustment of the greater number of disturbed children."¹

Finally, there is by far the larger group of children who may be able to continue in their normal school settings as psychotherapy progresses with the school psychiatrist, psychologist or social worker—and often enough a private psychotherapist—so long as the therapist is sufficiently flexible to provide ongoing support for the teacher and principal, who must live in daily contact with the youngster and his provocatively disturbing behavior. In fact, the therapist may find often enough that not only is he able to help the school community to tolerate the child during the treatment process, but that there are sensitive teachers who may be able (in consultation with the therapist) to contribute effectively to the child's treatment through the teacher-pupil relationship. Naturally, such cooperation presupposes a teacher and a school community that are sufficiently free from manifest emotional disturbance and are personally and professionally dedicated to helping the child in his growth as a person and not only as a Univac-like storehouse of information. Often enough, teachers and schools are unhealthy agents of repression and suppression; but then again, often enough, the therapist will find sincerely warm and mature educators who

are eager to participate in the treatment process.

In the therapist, the treatment process requires a person who does not panic at the first signs of anxiety in the teacher or the school, who is able to recognize the impact of his disturbed patient on those about him, who does not become defensive and offensive because of the insults he feels they are directing towards the patient with whom he himself identifies, and who respects the professional status of the educator. The therapist must be able to communicate an understanding of the child's dynamics in the real-life concepts of the layman without retreating into wordy technical formulations of psychodynamics; these would only betray his own fundamental lack of understanding and feeling for the unconscious processes that are determining the child's behavior in the world in which he lives. In the final analysis, the detachment of the psychotherapist from the teacher as well as from other significant figures in the child's life—when there are possibilities of cooperation and when a broader treatment approach is indicated—betrays the therapist's defense in professionalism which is intended to mask his own anxiety about his competence as a therapist and, ultimately, his adequacy as a person.

The therapist who succeeds in establishing an effective working relationship with his patient's teacher will find many rewards accruing to the child, the teacher, the therapist himself, and ultimately to many other children in the school community (who, after all, are also the concern of the sincere clinician devoted to his calling). The clinician who takes the trouble to think back to

¹ Hay, Louis, "A New School Channel for Helping the Troubled Child," *American Journal of Orthopsychiatry*, 23(1953), 676.

the early days of his own training soon recalls the many moments of bewildering confusion in these first exposures to the unreasonable, strange, provocative, often uncanny behavior of his patients; he is then able to feel more sympathetically the emotional plight of the teacher who is confronted by such children. Frequently, a teacher left to his own resources under these circumstances will build defensive retaliations against the child, which can be devastating in their impact. Happily, we often see that simply knowing that a child is under diagnostic study (or, better yet, under treatment) will forestall such unconscious reactions by the teacher, who now feels that someone else is sharing his terrible burden and that if he is patient relief will be forthcoming. At the very least, a general intellectual understanding that a youngster has had a "hard time" in his life, or that he is a psychiatric patient, will help a teacher invoke certain defenses against the angry retaliatory feelings that may be welling up inside. In reality, working with the teacher and school will often forestall their taking serious administrative action which can be permanently injurious to the patient, such as demotion, inappropriate placement in retarded grades and even total exclusion from school. At best, communication between therapist and school may help the teacher develop a meaningful emotional understanding of the disturbed child and an understanding of his own relationship difficulties with this child around which specific treatment techniques may be attempted in the classroom.

Billy would throw a tantrum every time gym class was scheduled or, more subtly, just before gym time, so that he was already in too much "hot water" to be allowed to go on with his class. Sometimes he would simply refuse defiantly to go on to gym; at

other times he would actually run away and wander off in the school building; on still other occasions he would launch into fairly serious acting-out defiance, including destroying school equipment. On these occasions the teacher would characteristically insist on Billy's going along with the group, but with predictably unsuccessful results, of course. Needless to say, the consistent outcome of this struggle was a seriously upset teacher and a seriously upset child.

In conference with the teacher, the therapist was able to communicate the tremendous phobic anxiety that Billy suffered around the gym, disguised in his angry, negativistic acting-out, and explained that the threat of close contact with other boys was too great for him to tolerate at this point. It was agreed that instead of attempting to force Billy into the gym activity, they would work out with him more socially appropriate ways of gaining permission to skip this class. The teacher explained to Billy that he understood how upset he was about gym, and said that of course it would be possible for him to have some other activity during these periods so long as he was too uncomfortable to go along with his class, but stressed that the important thing was that Billy be able to ask his teacher to be excused instead of resorting to all the negative techniques he used to escape.

The result of this approach was that much of Billy's severe acting-out in school soon ceased, and a warmer relationship developed between him and his teacher which proved beneficial to his growth in many subsequent situations. From the point of view of the therapist, the teacher's efforts helped his patient to acknowledge the anxiety which generated his symptomatic behavior, and accelerated clarification of the anxiety in treatment. During that year, Billy was able to work through in

Psychotherapist and Teacher

CHARNY

treatment the homosexual panic that was triggered by gym activities, and a year later—on his own initiative—began taking part in gym classes.

Paul was a 4th grader who had been doing failing work for several years and was recommended by his teacher for placement in a class for retarded children. On mandatory screening by the school psychologist it was discovered that Paul was in fact an unusually gifted youngster who even at that time was able to achieve a Stanford-Binet IQ in the superior range. Further clinical appraisal suggested that Paul showed surprisingly hopeful potential for treatment, especially if his family could also be involved in treatment as indeed they soon were. Paul began treatment and on the therapist's recommendation was promoted to the next grade at the end of that year, even though his work still showed no significant improvement. The therapist encouraged the teacher not to hesitate to communicate to Paul on the level of his known intelligence even though she should not immediately expect any striking changes in his performance. Following her initial amazement and utter disbelief, the teacher began to report a significant change in her perceptions of Paul and a feeling of growing warmth in her relationship with him. At this point the teacher became so taken with him that she was reluctant to record the failing grades he was still making and instead suggested that Paul be given "T" grades for trying so that he wouldn't be "hurt." The therapist helped her to understand how Paul needed to learn to evaluate realistically how poorly he did in relation to his real abilities, and that moving in the direction of minimizing his failings would be as harmful to him as failure to recognize his real potential.

Paul is now continuing in treatment and

recently achieved a series of excellent grades for the first time in his school life.

One important result of effective ongoing communication between psychotherapist and teacher, and especially in a residential treatment setting or a school treatment setting such as Rochester's "EE" unit, is that the teacher does not feel left out of the treatment program, a "second-class citizen" to the omniscient clinician who seems to be enjoying all of the prestige and emotional rewards of the patient's progress. A parallel that comes to mind for the clinician who has been associated with a progressive psychiatric hospital is the tremendous boost in the morale of nurses and attendants who are included on the professional team, and the truly productive work they do where their professional status and skills are respected. Such settings show especially clearly how a well-formulated total treatment plan provides a flexible framework for increased understanding of the patient, encourages more acute and insightful observations, and provides the directions for future modifications of the treatment plan as they are needed and understanding of the patient permits. Even the therapist who is inclined to emphasize almost exclusively the focused psychotherapeutic session will find that periodic communications with the patient's teacher may help him to understand features of the case that might otherwise remain obscure for some time.

Harold is a youngster with undescended testicles who was referred for treatment because of severe anxiety and mood swings. It soon became clear that the undescended testicle condition was an important focus of Harold's character problems and symptomatic reactions. For example, later in treatment it turned out that Harold thought the real word was "intesticles" (even though

the word had already been used many times before in previous sessions) as if to say that he dared not conceive of his testicles being out and therefore exposed to the dangers he felt. Still later Harold was able to say that he didn't want any testicles because they weighed him down, that instead he wanted to be a teddy bear and in this disguise continue to enjoy the love of his mother, which he felt would be lost if he no longer concealed his genital urges. In his behavior with other children he showed a tremendous pressure to exhibit himself and to dominate others to the point where he regularly built up into literally exhibitionistic frenzies.

One day Harold became so upset that the teacher called his therapist, a school psychologist, on an emergency basis. Harold was so upset on this occasion that he even went for a kitchen knife in the playroom (although the therapist felt there was no realistic danger of his using it). His verbalizations centered insistently on angry threats that he wanted to hit his teacher "in his big balls." He belabored this feeling so intently that the therapist volunteered the interpretation that he seemed to be concerned about the condition of his body and was furious at his teacher for being so big because he himself felt so insignificant that day. This interpretation had the significant effect of calming Harold down and permitting him to return to the classroom a short while later. He was able to get through the rest of the day without any untoward incident. Later, in conference with the teacher, the therapist learned that just that morning Harold had been examined by the school physician. The teacher was greatly relieved by the therapist's helping him to understand how the panic that followed was triggered by Harold's intense anxiety around the physical examination.

Later in the year when Harold was to receive an injection from the school physician the teacher consulted the therapist about preparing the child for this ordeal. Arrangements were made to capitalize on the anxiety that was triggered by this experience by scheduling a treatment session shortly thereafter. After two panic withdrawals to the therapist's office just before the physician could inject him, Harold went back a third time and was able to "take his medicine."

There is, however, also the other side of the coin to therapist-teacher communication which advises against unduly frequent or even regularly scheduled contacts in many situations, let alone in the numerous cases in which the therapist will not need to initiate any contact at all with the teacher. School clinicians especially, because of their responsibilities to school administrations, are prone to find themselves saddled with ritualistic obligations to meet with teachers at little gain to their patients. It is not unusual, for example, to find a teacher acting out his own unconscious needs in repeated bids for the clinician's attention, but because the contact is ostensibly around a child's needs and is further disguised by professional protocol it is often very difficult to work out the real issues.

Above all, there is the therapist's responsibility to his patient to insulate the treatment situation from everyday family and community pressures. The delinquent youngster, for example, requires a patient, concentrated acceptance from the therapist who, by his own conviction as well as the understanding of the community in which he is practicing, should be separated from those reality figures who necessarily must deal with delinquencies as they arise in any community. To introduce the issues of a youngster's outside misbehavior into treat-

Psychotherapist and Teacher

CHARNY

ment prematurely may destroy the possibilities of a therapeutic relationship.

Danny is a youngster with a history of hyperactivity, lying and stealing. In treatment, however, many weeks passed by with Danny guardedly avoiding displaying his symptomatic behavior. He was certainly a frisky youngster but not unmanageably hyperactive, and he used his treatment appointments to enjoy playing games with the therapist amidst a good deal of bodily cuddling. At the same time, however, his behavior in school continued to be erratic and uncontrollable, and he was periodically getting involved in serious misbehavior which he denied with seductive sincerity. On the basis of this information from Danny's teacher, the therapist began to inquire actively into how Danny was getting

along in his class, and soon Danny's problems were appearing progressively in the treatment situation itself. Unhappily, the result was not the acceleration of treatment that had been hoped for. Instead, bringing the issues of Danny's delinquencies into treatment before he himself could do so spontaneously left him unable to separate his therapist from the school administrators and ultimately from his own punitive mother. It was eventually necessary to terminate treatment and refer Danny elsewhere for the help he needed.

In the final analysis, effective communication between the psychotherapist and teacher requires of both mutual respect and sincerity of purpose. Therapist and teacher will find such professional cooperation a stimulating challenge and rich in its rewards for all.

Cooperation

Certainly, the benefits of further cooperation are unlimited. To bring about more of this kind of accomplishment, we must eliminate unproductive rivalries and interminable wrangling which do immeasurable harm to our cause and bring public discredit upon both of us. It takes two to feud; two to quarrel. But these same two can unite their efforts; they can pull together; they can work wonders for the people they serve. As Thomas Carlyle wrote: "Men's hearts ought not to be set against one another, but set with one another, and all against evil only."—Gunnar Gundersen, M.D., president of the American Medical Association.

MORRIS PARMET, M.D.

Flexible use of child guidance personnel in a rural medical center

Comprehensive medical care today recognizes the importance of balance between the physical and the emotional well-being of the patient. The concepts of good patient care have extended beyond the confines of the hospital into the community. In somewhat the same way, we shall be describing a child guidance service that has moved beyond treatment of the individual patient and his family into a concern for the general mental health of a community. It has done this as part of a comprehensive program of medical care being offered in a rural area.

Dr. Parmet, who is director of psychiatric services at the Hunterdon Medical Center, presented this paper in New York in March 1956 at the 33rd annual meeting of the American Orthopsychiatric Association.

The setting is Hunterdon County, N. J. (population 45,000), and the program takes place at the Hunterdon Medical Center in Flemington. In the early days of planning this medical center, something broader in scope than the typical small county hospital was envisioned. Aware of an almost total lack of health and welfare services, far-sighted members of the community planned that this medical center would encompass such services or provide leadership in their development. The board of trustees underscored this thinking in their philosophy that the emotional well-being of the patient was to be an integral part of patient care at the medical center.

Therefore, when the Hunterdon Medical Center opened its doors in July 1953, among the staff, composed of the county's general practitioners and nine full-time specialists,

Use of Child Guidance Personnel

FARMET

was a child psychiatrist, a psychologically oriented pediatrician and a supporting staff consisting of a psychiatric social worker, a clinical psychologist and a public health nurse consultant. This staff reflected the vitalizing role which the child guidance service was to play in the new program.

With a focus on the preventive aspects of psychiatry, a child guidance clinic was projected to replace the only previous psychiatric facility in the community, a traveling state-operated clinic which had served the area one day a month. The establishment of a child guidance clinic was also to provide a structural base from which other activities in mental health would follow.

The conferences and meetings with a cross section of local groups which ensued opened up for the child guidance team an awareness of the paucity of social resources in the area. Also, in meeting after meeting numerous troubled situations were mentioned. Whether services would be used was not known, but it was correctly assumed that Hunterdon County had its share of mental health needs. The nature of these needs pointed up immediately that the job to be done went far beyond the confines of a treatment service and would include mental health education and orientation as well as the promotion of mental health concepts in the wider community. This would have to be accomplished by a numerically small staff simultaneously carrying on a program of treatment.

To carry out their objectives, however, the child guidance team soon found auxiliary assistance within the very structure of the Hunterdon Medical Center. The inclusion of a psychologically oriented pediatrician and public health nurse consultant in the table of organization meant that sound mental health practices in medical care were developing in the center and reaching out into the community concur-

rent with the operations of the child guidance team. With the recognition that in such a small community and with such limited staff it would be uneconomical to duplicate efforts, it became necessary to establish in fact as well as in name a coordinated mental health team.

This now cohesive group began to examine the goals of the medical center in its mental health activities, their relation to ongoing programs and, in addition, the special skills inherent in the mental health team. It recognized the slow and uncertain use of the child guidance service in contrast to the more active use of treatment services for adults, and assessed the requests being received for education.

To give further background to this picture, it should be emphasized that this highly trained group of professionals in mental health had not come to Hunterdon County as a result of any organized movement to bring such services to the citizenry. This community had not experienced the learning process and the travail so common to communities seeking a mental health program. The community had wanted good medical care and had accepted the inclusion of mental health facilities as one aspect of this, but did not yet know their use or value.

The provision of the existing program had been made possible by a grant from the Commonwealth Fund in recognition that the community was as yet not ready to bear the cost of mental health services, although the medical center saw them as an essential part of its program of comprehensive medical care.

The mere provision of the services did not, of course, imply community readiness for their use, and our task was to explore the spots at which community readiness and our own skills could meet. We were aware of resistances which would be encountered related to our very newness and to the real

or implied threat that the professionals posed for those individuals already carrying some type of mental health responsibility. In addition to providing treatment, we considered the possibility of providing intensive mental health education to key personnel in the community, such as teachers and ministers, so that they could presumably apply "mental health first aid." We also considered the feasibility of setting up a program of preventive intervention. Both of these concepts, however, imply a more aggressive role on the part of the professionals. For them to be successful, there would have to be more reaching out from the community, some evidence of desiring and supporting such programs. Our early experience showed that it would be more expedient to revert to the sound principles of letting the people of the community know what was available and providing them with an opportunity to move towards the utilization of our services at their own speed.

The way in which this began to unfold is best portrayed through the activities of the members of the team as they operated separately and collectively. At times we will use the phrase "mental health team" activities almost interchangeably with "child guidance unit," and in truth our developing way of operation had the pediatrician and nurse consultant operating peripherally as members of the child guidance service, just as in other areas the child guidance unit and nurse consultant served as appendages of the pediatric service. Although we had our separate and individual existences, there were special areas of professional endeavor where we coalesced in our performance. To the degree that individual strivings could be subordinated to overall needs, so could a small group hope for success in a program with numerous and far-reaching tentacles. We cannot describe all of the activities of the

team but will attempt a capsule representation of each team member's efforts.

Within the medical center itself arose an opportunity for collaboration of the obstetric service and the team in a request to set up classes for expectant parents. The psychiatrist and the pediatrician participated but the actual leadership was assigned to the nurse consultant. Out of her leadership came our realization that in this team member we had a person with skills and interest in teaching normal growth and development at a group level. And as later groups formed in the P.T.A.'s, in the adult education schools and in the medical center, she began to lead discussions concerned with the emotional problems of living at a generalized level.

Soon new opportunities presented themselves which gave us entry into established community structures. A local township requested a demonstration program in school health. Our pediatrician, working primarily with children entering school for the first time, used the clinical psychologist and nurse consultant in his program of evaluating potential difficulties in school performance related to physical and emotional problems. The clinical psychologist was then made available to another township at their request to demonstrate the specific role of a school psychologist. In this she was related to the school's focus on learning problems in general, rather than to diagnosis and treatment of a specific child.

The psychiatric social worker, being also director of social services for the hospital, was in a position most sensitive to the overall lack of community services, and together with other community workers began to study and evaluate existing and potential needs and services.

The psychiatrist carried over-all responsibility for the coordination of mental health

Use of Child Guidance Personnel

PARMET

activities as well as for treatment services to children and adults. His own educational activities, although including lay and parent groups, were focused on helping allied professionals to enlarge their own areas of competence. In addition, because of his integration into the hospital's program of medical care he had an opportunity for the psychological orientation of all staff, medical and non-medical, professional, student or volunteer.

But not only was the psychiatrist used in a variety of ways to extend good patient care; the entire team was available for evaluation, consultation and the implementation of sound medical care practices in nursing and after-care planning. The team was, of course, most closely related to the pediatric service as participants in weekly ward rounds, pediatric conferences and individual consultations. From the use of psychiatric consultation alone developed the active use of the team to implement such mental health concepts as the inclusion of parents in the care of the hospitalized child.

In the extension of services made necessary by the many facets of the program it was seen that early symptoms of behavioral disorders might well be treated by the pediatric service. In other instances the pediatric floor might be used as a temporary residential facility for an intensive evaluation of children seen in the child guidance service.

And within the child guidance service itself there was need for many departures from conventional practices. Since only one psychiatrist and one psychiatric social worker serve the medical center, treatment cannot always be handled on a collaborative basis. With the absence in the community of both child and family service agencies the social worker sometimes found it necessary to assume such functions. Situations

were also encountered where both parent and child were so disturbed that simultaneous treatment might need to be attempted by the psychiatrist. Unconventionally also people came for help who would ordinarily be referred elsewhere—friends, neighbors and associates. To turn them away might have meant a total denial of help. This imposed a special burden on us, but it was the reality and would be characteristic of any such similar program in a rural area where a small group of specialists attempts to meet all mental health needs.

We have several times referred to the charge on us to meet the mental health needs of our community as part of a comprehensive program of medical care. It is perhaps less presumptuous to state that we were aware from the beginning that we could not do this alone. We did begin by offering a core of treatment services to adults and children within the medical center and in the child guidance service. Out of the response to these services, we were able to assess more realistically the community's needs for education and for broader programs designed to define and combat incipient emotional problems. In making the skills of our team available in a broad sense we have been able to encompass some treatment, some education both to impart a better understanding of mental health concepts and to awaken knowledge of potentially pathological situations, and some preventive activities in the form of anticipatory guidance with parents and school personnel both. In all of these activities the professional team has had the function of constantly identifying forces in family or community inimical or supportive to sound personality growth.

To implement such a comprehensive program, however, there is always the need for community support and understanding of the aims and objectives of the professional.

Hunterdon County now has a Mental Health Association, but only after several years of intensive planning and activity by the mental health team in conjunction with a mental health committee of the board of trustees of the medical center. Hopefully this association will become the community arm of the mental health services of the medical center and the medium through which the concerns of the professional staff around the prevention and treatment of emotional problems may be transmuted into a community program which will provide an optimum setting for sound personality development. The association will also be in a position to rally tangible support for mental health services in the future.

In presenting our program and our problems it is important to emphasize that we did not extend or modify our functions haphazardly. Our program represents a purposeful adaptation to an existing set of conditions. Child guidance services can maintain a meaningful existence only in a favorable milieu. Our service has had to

be unconventional at times and has had to move into numerous byways of community activity. That it has been augmented in its functions by a pediatrician and nurse consultant on the one hand and by the supporting arm of the Mental Health Association on the other is most rewarding.

In sharing our experiences, we should emphasize one final point. Communities such as ours need personnel whose orientation goes beyond concern with the intrapsychic processes of the patient and his family. It should not be inferred that rural communities have fewer pathological situations requiring careful and skillful therapeutic measures. The psychiatrist is here, as everywhere, under pressures to treat seriously disturbed patients, but when his sights are on a broad mental health program for a community he must be willing to devote considerable effort to the development of other resources for prevention and education, so that the treatment he extends is not handicapped by an unfavorable social climate.

DAVID HALLOWITZ

ALBERT V. CUTTER, M.D.

The pre-intake phase

The beginning of the intake process

In a child guidance clinic, telephone contact, prior to the face-to-face interview with the parents, constitutes the very beginning of the intake process. This important phase of intake practice was opened up for further consideration by Paul Widem's article, "The Telephone Intake Interview in a Child Guidance Clinic."¹ Discussing the telephone interview's "value, limitations and dynamics," Widem shows how the case-worker sensitively and skillfully begins to help the parent at this early point with his or her uncertainty, anxiety, confusion and feeling of guilt. These are some of the major dynamic elements he presented: the worker "conveys through tone of voice his interest in the client's problem and wish to support the parent"; he provides reassurance by wishing "to know a few facts about the problem in order to determine

whether the clinic can be of help"; and he "offers immediate service to critical cases."

There is need to build up Widem's important contribution by examining in more detail the exploratory and helping aspects of the pre-intake phase, which may consist of one or more telephone conversations with the parents. The thinking and practice intensively developed by the Guidance Center of Buffalo over the last three years may be a step in this direction.

In our clinic's history—and this may be true also of many other child guidance clinics—the office secretary routinely used to schedule intake interviews, getting only

Mr. Hallowitz is the assistant director and chief psychiatric social worker and Dr. Cutter the medical director of the Guidance Center of Buffalo.

¹ *Social Casework*, 38(November 1957), 485-89.

the briefest description of the youngster's difficulty. Five years ago this became a professional responsibility. Even so, however, the amount of information gathered on the phone, and the dynamically helpful responses to the parents' feelings, were brief and minimal on the assumption that a face-to-face intake interview was an essential first step to becoming involved in a case. Referral to other helping resources was done at the point of the initial phone conversation only in very clear-cut instances of a case not being appropriate for the clinic.

About three years ago, the pressure of the large number of intake interviews and the ever-growing waiting list compelled a more extensive use of the initial telephone contact. We had been finding that time-consuming intake interviews often resulted in referral of cases to family and child care agencies; and that cases already in diagnostic evaluation and treatment were more suitable for these agencies. Could we use the pre-intake phase more effectively for screening purposes, we asked ourselves?

As we proceeded to explore this, we found that we were being of more immediate help in referring cases to other community resources. A 1957 survey revealed that 32 referrals were made to family agencies during the pre-intake phase, as compared to 110 cases accepted for clinic services—22½% of the total of these cases. We found also, in our pre-intake work, that we were getting a fuller picture of the problems in a case, which was useful in the face-to-face intake interviews; and that the relationship between the clinic and parents was, in a beginning sense, being formed.

Let us now turn to the dynamics, process and specific content of the pre-intake phase.

The fact that a parent calls the clinic does not always mean he has made a clear decision to seek help. Parents' attitudes in this

regard can vary from an urgent unconflicted wish for help, to ambivalence, to toying with the idea, and to being almost opposed (as may happen in authoritative referrals). In any event—but more so when parental decision to seek help is marked by conflict and uncertainty—the parent subconsciously assesses the worker's attitude, as conveyed through his responses, and its effects upon the parent's own feelings. For example, in a given situation, the worker might play down the problems presented by the mother because he failed to sense fully the covered-up parental anxiety, or because he wanted to be reassuring and supportive, or because he honestly felt that no real problem existed, and so forth. Even though the mother herself might have tended to minimize the problems, the worker's doing so—for whatever reason—may well give her a negative set to the clinic and may dam back her seeking help.

The showing of honest-to-goodness understanding of the parent's distress is done through dealing empathically with the feelings detected in the phone conversation, maintaining objectivity as well. For example, the parent might express grave doubt about the clinic's ability to be helpful, or negative feelings toward psychiatrists or clinics or toward professionals in general. The worker expresses his understanding that the parent has mixed feelings about seeking help and has some fears about this as well. He encourages the parents to come in for a talk with one of the staff members about the problems troubling them.

The foregoing indicates the importance of handling telephone contacts in a clinical way. The telephone interview is not merely a medium for fact-gathering. It is a medium also for showing real understanding and acceptance of the parents with problems of their own as well as with the problems that pertain to their child.

The Pre-Intake Phase

HALLOWITZ AND CUTTER

Because the telephone contact has this important clinical aspect, the general principles of face-to-face interviewing are applicable.

As the parent expresses herself about the child's problems, the worker gets a beginning symptomatic picture. He also gains a beginning awareness of parental feeling about this, not only from what the parent actually says, but on a non-verbal level too. It is often possible, for example, to detect whether the parent is at ease, hostile, anxious, bewildered, confused, fearful, withdrawn or depressed. It is necessary for the worker "to be where the parent is." That is, if the worker can feel with the parent, he will be able comfortably to convey respect for and understanding of her, and help her to reveal more freely her dilemma.

In this context of empathic feeling, if the worker does not understand the problem as presented, he can say so and feel secure that the parent will not be offended but will try to clarify it. The distraught parent may seek direct answers to questions. The worker must be free to admit that not knowing more about the situation, he cannot with honesty answer the question. The admission of "I don't really know" can be an important dynamic.

Silence on the other end of the phone may be handled with an empathic comment such as "This problem has been most upsetting to you" or "It is most difficult for you to talk about this problem" or "It really was difficult for you to call." Such a comment shows understanding of the embarrassment or fears or worries which the parent has in calling and coming finally to a starting grip with the problem. Also, it may release a flood of feeling, and with this an ability to talk further about the problem.

It may be important to identify with the parent and the effect of the problem on the parent. For example, an appropriate "I

know just how you felt" or "I don't blame you for feeling that way" or "I see what you mean" may also allow for further expression of feelings about the child or about other members of the family.

In other words, the sensitivity and skills of the worker are qualitatively the same in the pre-intake phase as they are in the face-to-face interview. The difference lies only in the amount, kind and depth of content.

The helping process begins at the very moment the parent picks up the phone to call the clinic. Thus, the receptionist-telephone operator—whose manner must be friendly—has an important responsibility. If the intake worker is not readily available, the receptionist asks for the parent's name and phone number, gives her in turn the name of the intake worker, and assures her that he will call her back soon, or at least that day. If the anxious parent has need to "spill" to the receptionist, the latter assures her further that the worker will go into this in detail. The receptionist leaves a message for the worker, including any content the parent has imparted.

The worker's initial telephone conversation with the parent lasts about 15 minutes. It is usually the mother who calls, but sometimes fathers take the initiative. After greeting the mother and giving his own name, the worker will say in effect: "I understand you are having a problem with your youngster." Even though the worker in some instances may already have a fair amount of information about the case from the referring source, he will merely refer to this and ask the parent herself to tell him about her concerns.

The first problem mentioned has special significance because it often means—not always, of course—that this is uppermost in the mind of the parent for which help is being sought. For example, the school

referred a youngster primarily because of stuttering but the mother did not mention this in her opening remarks. She was more concerned about his being high-strung and nervous. The subsequent intake interview bore out the fact that the parents had only secondary concern about the symptom of stuttering.

In an effort to gain a well-rounded picture of the child's problems, and of the environmental circumstances impinging upon them, the worker helps the parent to enlarge upon the specific problems she first presents and to consider other possibilities. As discussed above, the worker's warm interest, gentleness of approach, sensitive-empathic and supportive responses must be inherent throughout the telephone conversation.

In developing a full symptom picture on the phone, the worker—mostly in the context of what the mother is saying but sometimes directly too—asks such questions as "How is your youngster getting along in school?" "Is there any question about his basic intelligence and ability to learn?" "How are his relationships with other children in his class?" "With his teachers?" "How does he get along in the family?" "With father?" "With mother?" "With brothers and sisters?" "Does he wet the bed?" "Bite his fingernails?" "Suck his thumb?" "Does he have such other nervous mannerisms as eye-blinking and facial twitches?" "Does he have friends and playmates in the neighborhood?" "Are there any outstanding physical or medical problems?" The worker will ask specific questions about gross and fine coordination, hyperactivity, and—in rare instances when the symptom picture leads up to it—blank spells and convulsions. This is especially true when the parent gives clues about the possibility of mental retardation or brain damage.

While talking about the child, the mother may already have given the worker some information about the family situation. She may have volunteered, for example, that the child does not have a father owing to death or divorce; that there are one or more relatives living in the home; that both parents are working, spending little time with the children and leaving them unsupervised most of the day; and so forth. The worker can then use what the parent has already related to help her enlarge upon the family picture. If the parent has not as yet told anything about the family, the worker can ask: "Is there any problem within the family that might have a bearing upon the child's difficulties?" The parent usually brings out that which is significant. Often, too, the parent will interpret the question in part to pertain to the marital relationship. A direct question about the marital relationship also can be fruitful. The mother may say that she and her husband get along well together. From the subtle qualities with which this is said, the worker might be able to discern whether this is a guarded or frank response. On the other hand, the mother may say that there has been much conflict between the two. If there has been a history of separation, the mother may then bring this out as well. The worker also inquires about the father's interest in getting help—if it is the mother who calls—and the response gives further indication about the quality of the marital relationship.

It is to be noted that the worker does not ask the parent about her ideas of causation, nor encourage her to express herself in this regard. This gets into deeper psychodynamics and requires much more time than that allowed by the limits of the telephone conversation. Moreover, the deep, complex and subtle conflicts and feelings in the parent-child and inter-parent relation-

The Pre-Intake Phase

HALLOWITZ AND CUTTER

ship can more effectively be handled in the face-to-face intake interview, and in ongoing work with both parents.

The worker asks about possible previous contacts with other clinics or agencies. Depending upon the nature of the previous agency contact, the worker might help the parent return to that particular agency. Such a routine inquiry at the point of the initial telephone contact can save the clinic and the family much valuable time.

Usually parents readily understand and accept our need for school, medical and other reports and give their consent to our writing for them. If the parent hesitates, the worker expresses awareness that she has some doubts or misgivings about this. She will then bring out her feelings and these are discussed mostly in an interpretive way. If the worker senses that the mother's feelings are not resolved, he will tell her that we will forego sending for reports and suggest that this can be discussed more fully when the parents come to the clinic for their first appointment.

For example, a mother was opposed to our sending for a school report because she was afraid that the contact with the clinic would become known to the teachers and pupils. In addition, she wished us to form our own conclusions about the child's learning difficulties and not be prejudiced by the school's psychological test findings. The worker explained that in our experience schools handle such matters responsibly and confidentially and that our diagnostic evaluation would not be influenced by the previous work done. The mother reluctantly said, "If you feel you have to, then go ahead." The worker replied, "I see that you really would prefer our not getting in touch with the school and I surely understand your feelings. I won't send for this report, but let's talk it over further when you come in."

As the phone conversation nears an end, the worker thinks differentially about several possible courses of planning.

1. If it appears that the case is possibly but not clearly for the clinic, the worker may feel the need for collateral information from the school, physician and other social agencies before arriving at a decision for an intake interview. He will then talk this over with the parent and come to the understanding that he will be in touch with her after receiving these reports.

Similarly, the worker may wish to consult with the medical director and will explain this to the parent as well.

2. In complex situations where the worker has consulted with the medical director, he may explain in a second telephone conversation the need for preliminary studies beyond the clinic before planning for the intake interview. He will then actively help the parent become connected with the particular community resources at which the studies will be done. When certain kinds of symptoms are present, perhaps a complete neurological work-up is necessary as a preliminary measure.

For example, in one case it was apparent both from the initial telephone conversation with the mother and from the reports received from the family physician and the school psychologist, that a neurological study should be done. Without arranging an intake appointment, but with the permission of the mother, the medical director and the worker conferred with the family physician and the school psychologist. We were all agreed upon the necessity for neurological study. This was done and it was found that the child had a brain tumor, which was successfully handled through surgery.

3. In less complex cases, the worker can independently recommend a preliminary study before planning to see the parents in an intake interview.

In one instance, a mother was quite upset and anxious about the fact that her son began to lose his balance and fall backwards. Because the child was also emotionally upset, she thought the most recent symptom to be emotionally determined. Asked if she had gone to her physician with this problem, she replied that she had not. The worker therefore suggested that she do so without delay and then, with the physician's help, we could determine whether or not our services were needed. The mother reported back later that she had gone to her physician and that he had found a physical basis for the symptom and was effectively treating it medically. The child's emotional upset cleared up also.

In another instance, where stuttering was the only presenting problem, the worker recommended a speech evaluation to determine if the problem had an emotional or a physiological origin. The report subsequently received stated that the child was in need of our clinic's services. The parents were then seen for intake interviews. In other situations involving stuttering, speech therapy instead of psychotherapy was recommended.

In a third instance, the only problem evident in the full telephone conversation with the mother was that her daughter was not progressing well academically. To the mother's knowledge, the school had not done any psychological testing. Believing that the school had a responsibility to check into this further, the worker arranged for the school psychologist to see the child. The latter found definite intellectual limitations, and on the basis of this finding the school changed its educational approach. A follow-up telephone conversa-

tion with the mother revealed that the foregoing was discussed with and accepted by the parents. A second follow-up telephone contact three months later showed that the child was doing better and that the parents were satisfied with the school program for her.

4. In certain kinds of cases it is occasionally possible to omit the step of a separate intake interview with the parents, and to schedule this to coincide with the child's first appointment for diagnostic evaluation. This occurs when the symptom picture obtained on the telephone is almost entirely in the realm of possible mental retardation, organic brain damage or other unusual physical and medical factors. If there is an emotional problem, it probably stems from parental confusion and lack of understanding about such factors. Consequently, to be able to help them, it is essential first to work out a differential diagnosis of the child through psychological and psychiatric examinations. The emphasis in the telephone contact would be upon getting the symptom picture, learning fully about previous studies and getting permission to obtain reports of these studies. For example, the pediatrician and parents of a 3-year-old girl wished our help in making a differential diagnosis with respect to symptoms of cerebral palsy, mental retardation and emotional disturbance.

5. There is one group of cases in which it is difficult to determine whether the services of a child guidance clinic or of a family agency are needed. These are the cases in which there are major family problems of a kind that ordinarily are appropriate for a family agency but in which the child is presenting symptoms of emotional disturbance.

It is possible to formulate only general

The Pre-Intake Phase

HALLOWITZ AND CUTTER

criteria which have to be applied flexibly to each individual case.

If the child seems to be quite disturbed emotionally despite major family problems we will at the very least explore the situation further through an intake phase and a diagnostic evaluation of the child and the family. A mother once told the worker only about the problem of poor school adjustment. In response to his further inquiry she revealed that her daughter had tics and nightmares and walked in her sleep. The surrounding familial circumstances might have prompted the worker to suggest a family agency, but upon learning that the child's symptoms indicated a probable deeper disturbance than the single symptom of poor school adjustment would lead one to believe, he planned with the mother for an intake interview.

On the other hand, if the child's symptoms and problems seem to be a direct outgrowth of severe social pathology within the family and if the symptoms and problems do not indicate severe psychopathology within the child, we refer the case at the point of the initial intake inquiry to a family agency. Some factors in the family suggestive of referral to a family agency are repeated separations between the parents, general family disorganization, previous break-ups of the family with placement of the children, numerous moves by the family from one community to another, both parents working and several relatives living in the home, more than one child showing signs of disturbance, and the parents having recently married each other following previous marriages, with the child apparently reacting to the new situation.

The working relationship between the two agencies should be such that, through conferring, the family agency should have the freedom to refer the case back to us or to suggest a cooperative treatment plan.

CASE ILLUSTRATION

In an anxious and excitable manner, Mrs. K related that since coming to Buffalo a year ago her 11-year-old boy has threatened to be "bad until we move back to Detroit." David evidently is attached to his grandmother in that city. He talks back, is very fresh, has been getting into sex play with his sister, and has kicked his sister. In school he does not sit still and his performance is erratic. Sometimes he will get zeros and other times he will get 100. He has kicked his teacher and has fought with other boys. He does not have any friends in the neighborhood or in school.

I asked if the parents had had worries about David when the family lived in Detroit. "Yes," she replied dejectedly, "for many years. I guess we should have done something about it long ago." I said I realized how difficult it is for parents to seek special help. As though this struck a responsive chord, Mrs. K went on to say that she had hoped David would grow out of it.

I asked about other possible symptoms of disturbance, mentioning them specifically. The mother replied that none of these applied to David—except that he wet the bed until he was 6, but the physician had said this might have been due to a sugar condition.

I wondered if there are any problems within the family to which David might be reacting. The mother then told me that she and her husband were separated for three years but came together again about a year and a half before her call to us. With troubled rather than angry feeling, she went on to say that the father beats the boy severely, leaving black and blue marks on him. He will punish the boy also by having him sit still for long stretches of time. He does the same to all the children.

The mother has found that there is no use trying to tell her husband how better to handle the children because he does not listen to her. Now, angrily, she asserted he has a terrible temper and a very mean disposition. I said that I can see how angry and upset she feels. After she expressed further her upset feelings about her husband, I commented that evidently they do not get along well with each other. The mother stated that this is true in some respects, but not in all. In response to my question, the mother replied that her husband is interested in some help being obtained for the boy but does not have too much conviction about this as yet. I said it would be natural if she too had some doubt about this.

I talked with the mother about applying to the family agency, explaining that it seems as if the entire family needs help. She then told me she had tried to reach this agency before calling us but could not get through on the telephone. I gave her more specific instructions, mentioning specifically the name of the intake supervisor. I suggested further that she call me again if necessary. She expressed appreciation for my help.

Follow-up telephone contact with Mrs. K a week later revealed that she was able to obtain an intake appointment at the family agency.

In making a referral to a family agency, the importance of follow-up must be emphasized. In our community it has been found that a large proportion of inter-agency referrals, carefully worked out on the basis of direct interviews, do not reach fruition.² This could be equally true—if not more so—for telephone referrals.

² "The Buffalo Self-Study: A Special Study Project of the Council of Social Agencies," 1957.

We routinely call the parent after a week has elapsed to ask if she has followed through on our recommendation. If not, this will be discussed further with her on the phone, and if necessary the parents will be invited to come in for an interview to discuss with us the entire situation. Several times this follow-up procedure has resulted in consummation of the referral.

Another function to keep in mind is that of informing the person who referred the case to us about our helping the parent get to another agency. This has value not only from the standpoint of good community relations, but as an additional safeguard. A school principal, for example, subsequently informed the worker that a mother was disappointed and angry about not getting service at our clinic and decided not to go to the family agency recommended. Thereupon the worker called the mother and arranged an interview for the parents, in which they were helped to work out their feelings about the referral and accept it.

6. In the majority of instances of course, it is clearly indicated that the child and the parents may well need clinic help and consequently an intake appointment is arranged.

CASE ILLUSTRATION

Mrs. F at once asked if Dr. J had called me about her 10-year-old daughter. I said he had and asked if the mother herself would tell me about the problems with Betty. In a halting and restrained manner, as if trying to keep from crying, Mrs. F told about Betty stealing money, candy and small articles at home and from stores. Three months ago she had confessed to her parents about all of this. The confession had been precipitated by her hearing in school about a theft of \$25. Following this confession, there had been "a complete change

The Pre-Intake Phase

HALLOWITZ AND CUTTER

of personality." Previously, she had been vivacious and since that time she hasn't had any spirit at all. The mother could hardly finish her sentence and was unable to go on. I said that Mrs. F is feeling very badly, at which she burst out crying. She apologized for not being able to control herself. I assured her that I knew she could not help crying because she does feel very upset and unhappy. Apparently more at ease after the release of feeling, Mrs. F went on to say that Betty has become very apologetic about every little thing—for example, the breaking of a toy. There has been no recurrence of the stealing since the confession.

I asked how Betty is getting along in school. Mrs. F replied that she does average or below-average work. Now in the fifth grade, she functions on about a fourth-grade level. She has particular difficulty with reading. Betty gets along "well enough" with the other children in school and in the neighborhood. Asked about Betty's relationship with the children in the family, the mother related that there is no unusual difficulty with her 13- and 6-year-old brothers. She "loves very much" her baby sister, now a year old.

I inquired specifically about other symptoms. Betty wet the bed until two years ago and has wet occasionally since then. She does not suck her thumb or bite her nails. Spontaneously the mother added that she rocks every night before going to sleep. Mrs. F went on to say that on and off for several years Betty has had spells of eye-twitching. They last for a week. The last occurrence of this kind of prolonged eye-twitching was about two months ago. At the present time, there is occasional and momentary eye-twitching. The eye doctor could find nothing wrong when he examined her for this condition.

I wondered if there is any problem in the family which might be upsetting Betty.

Mrs. F then related that the father's work as a salesman takes him away from home a great deal. The family life suffers as a result. When home, he seems to take more interest in the other children than he does in Betty. He has left most of the responsibility for Betty's difficulties to her. The mother paused and the worker purposely remained silent. Mrs. F went on to say that she and her husband have not been getting along too well together and there was a brief separation three years ago. There has been some improvement in their relationship since then. The mother confided further that at the time of the separation three years ago she had "a nervous breakdown" and was under the care of a psychiatrist for seven months. Now she sees the psychiatrist every once in a while. I remarked that Mrs. F surely had had a rough time. She expressed herself a little more on her distraught state at that time.

I asked if it would be all right with her if I wrote to her psychiatrist for a report. When she wondered whether this was really necessary, I explained that it would help us to have more understanding of her but assured her that if she really did not wish me to communicate with her psychiatrist, it would be perfectly O.K. Mrs. F unresistively gave her consent.

I asked if there had been any previous contact with other agencies in the community. She replied that they had not been to a child guidance clinic, but she and her husband had gone to a family agency four years before. They seemed to be making some progress but then her husband withdrew and she saw no value in continuing herself.

The mother gave me permission to obtain reports from the school, the pediatrician, the eye doctor and the family agency.

An intake appointment was arranged for both parents.

The pre-intake phase is not completed until the parents actually appear at the clinic for the intake interview.

The mother may call to cancel the appointment because of illness or other reality factors. The worker expresses sympathetic understanding and arranges another appointment. The same occurs when the parents fail the first appointment without informing the clinic beforehand, except that the worker takes the initiative in calling her. If there is a recurrence of a cancelled or failed appointment—again presumably because of reality factors—the worker may feel that the explanation is genuine and accept it at face value. However, if he senses parental difficulty in taking the step of actually coming to the clinic, he will empathically comment upon this. Usually the parent is thereby enabled to bring out the feelings that bother her—for example, "My husband is still not in agreement with me about getting help" or "Maybe we are making too much out of it" or "Will people think that by coming to the Guidance Center it means that my boy is crazy?" and so forth.

Feelings of this kind, of course, can be expressed at any point during the pre-intake phase. In the spirit of trying to understand the parent's feelings, the worker helps her to express them further. He verbalizes his acceptance of the parent's feelings, answers specific questions interpretively, gives his honest opinion about the child and parents being in need of clinic help, and suggests that mother and father think it over some more. If the parental decision at that point or later on is not to come to the clinic, the worker again expresses his understanding and acceptance, and assures them that they can get in touch with us at any time in the future should they feel the need to do so. Often this representation of the clinic's consistent interest and willingness

to be of help results in the parents, now or later, coming for the intake interview.

One can readily see the value of the entry of the telephone interview in the record of this case, and of the reports to be received, in preparing the worker for the intake interview or interviews with the parents. He will have in mind the various specific symptoms so that he can obtain a fuller picture of them, and ask when they first arose. Within this context, the developmental and medical history can be obtained. It may become possible to make connections between significant events and developments on the one hand, and the onset of particular symptoms on the other. For example, what was the effect on the boy of the trouble and upset between the parents? Similarly, the effect on him of the newest child's arrival? The intake worker will have the benefit of the psychiatrist's report on the mother and will now want to begin to assess her present state of emotional health, her ego strengths, and so forth. Problems in the parent-child and inter-parent relationship will need to be explored—toward helping them become aware of and understand their part in the child's difficulties.

In summary, we have seen that the pre-intake phase is a delicate and complex part of the intake process. Sensitively recognizing and empathizing with the parents' feelings about seeking help and about the child's problems besetting them, the worker develops a well-routined picture of these problems and of the social situation. The worker's approach is a clinical one in gathering and evaluating information and in conveying real understanding and acceptance of the parents. The authors have shown the principal similarities and the essential difference between the work with the parents through the medium of the telephone and that done in face-to-face in-

The Pre-Intake Phase

HALLOWITZ AND CUTTER

interviews. On the basis of a well-rounded picture of the child's symptoms and of the problem areas, the worker thinks differentially about alternative courses of help. In this, he functions as a member of the clinic team, consulting, when necessary, with the supervisor, medical director or other members of the staff. Preliminary studies prior to the arrangement of intake interviews are sometimes recommended, and help is given the parent in having them done.

The authors have presented the criteria for making early referrals to family agencies; the process of helping the parents be-

come connected with such agency; and the importance of follow-up procedures. Although regarded primarily as helpful planning for families, early referrals also bring about economies for the clinic in substantial saving of staff time and ultimately in a smaller and more manageable waiting list. Set forth also were the values of the material gathered during the pre-intake phase in preparing for intake interviews. The pre-intake phase is both the beginning and the bridge for deeper involvement of the parents through the ongoing intake process.

AARON L. RUTLEDGE

Perpetuation of non-value

The professions of psychoanalyst, psychotherapist, case worker and counselor are built upon certain values, among which are a commitment to the fullest self-realization of a patient or client.

The role of value conflicts as a source of pathology and the place of value in personality formation and in psychotherapy have been receiving increasing attention in recent literature. The concept of "value" as it applies to therapist has not been so popular. Perhaps as an outgrowth of attempts to divorce itself from its religious and philosophical heritage, early American therapeutic psychology in general built up an aversion to the topic. Even today it is not

an easy subject for clinical discussions. Often this vital area has been covered with two glib assumptions or pronouncements—hands off the patient's value system, and the therapist should strictly avoid exposing his own. Both are impossibilities and it is wiser that the therapist be alert to what is transpiring within himself and within the client. The total approach to counseling and psychotherapy—the perceiving, selecting, collecting, organizing and interpreting of data—is a function of value systems.

This treatise does not purport to deal adequately with the question of value itself, much less to analyze all concepts of values or systems of values. But along with Plato, Kant, Kohler and many modern psychotherapists it takes the position that at the bottom of all human activities are certain values, "intrinsic requiredness or wrong-

Dr. Rutledge is leader of the counseling service and the training program in counseling and psychotherapy of the Merrill-Palmer School, Detroit.

ness," the conviction that some things, in certain contexts at least, "ought to be" and others not. Insight is *all* awareness of such intellectual, moral or aesthetic value. Therefore, value and corresponding insight are the essence of mental life.

Whatever the system of thought, whether scientific or philosophical, as a part of its development there is a tendency to exclusivism whereby the values propounded by another system are denied. Although written several years ago, predating much of the recent rediscovery of value, Wolfgang Kohler's *The Place of Value in a World of Fact*¹ is still worth quoting:

"Scientists will insist upon 'objective procedure,' on 'careful verification,' or on 'genuinely scientific theory,' perhaps on 'the principle of parsimony' and on 'consistency.' Besides they will courageously defend freedom of thought, of research and of speech. Implicitly all this is accepted as valuable, as required. But the very next moment they will express their contempt of 'metaphysical speculations such as concern for ethics,' which 'cannot be submitted to the absolutely indispensable experimental test.' One begins to wonder whether logic would also have to pass this indispensable test—which is itself full of logical premises. Certainly in science we are not very clear about requiredness although our work is utterly imbued with it."

Inherent in much professional training has been the concept that to be effective the psychotherapist must be secure apart from, and be inwardly free of, the authoritarian values attributed to the conventional requirements of the culture. At times this has been misconstrued to say that he should have no evaluational goals while dealing with a patient. At best it is a long route from the fairly fixed value systems of the therapist's youth to a state of "inner in-

dependence" of these authoritarian, culturally determined "things that ought to be." It is a still longer route to the development of an autonomous value system or philosophy of life for the therapist as a person. Many get lost, or live out a good part of their professional careers in the no man's land between outmoded and discarded value systems of the past and the emergence of a new meaningfulness that makes life a thrilling adventure.

It is this process of constantly exposing a budding philosophy of life to culture in general and to differing systems of value in particular which sharpens the perception of the developing psychotherapist, enabling him to deal helpfully with the values, lack of values, hierarchy of values and communication of values in a variety of patients. But since what the therapist essentially is gets to the patient through the healing relationship, he may fail to help and even hinder many who are struggling to find a more meaningful philosophy of life. He cannot lead them farther than he himself has traveled. In fact, unknowingly, he may help to perpetuate in the patient a system of "no value," or absence of value. This leaves the patient with an even greater divergence between what he has grown up to expect of himself and what he is. The patient may be less anxious for a while because of the beginning of new expectations of himself, but the risk is that he levels off in development where the least is expected without adequate new goals to direct his development and creative functioning. There is in man a remarkable tendency to be soothed and satisfied whenever a problem, instead of being solved, has merely been located somewhere.

¹ New York, Liveright Publishing Corporation, 1938, p. 36.

Kohler² came close to this position:

"When once born in the universities, the spirit of Nothing But does not remain confined to these institutions and to scientific books. Future teachers absorb this spirit in lectures and in reading. Afterwards they propagate the same spirit in high schools, both by what they say and by what they never mention. Enlightened writers do likewise when writing in newspapers and in magazines. Thus negativism spreads through a population like an epidemic. . . . Gradually Nothing But becomes the unformulated creed of your post-man, your politician and your prime-minister."

He went on to say that as this stage is reached people are void of any stable convictions beyond immediate personal interests. No principle is worth defending, because, after all, "What is a principle?" Without any conviction at all nobody can be expected to live courageously.

At the risk of being misunderstood, and of overdramatizing, the following may demonstrate what, for lack of more descriptive symbols, can be thought of as perpetuation of "non-value" which has reached serious proportions in clinical circles from the standpoint of patient and therapist alike.

Since the psychoanalyst is the parent figure to many of the clinical disciplines—including psychiatry, much of clinical and counseling psychology, social work, marriage counseling and pastoral counseling—he is a good beginning place. For the sake of

argument, take an analyst who has become relatively free of inner constraint by authoritarian expectations out of the past or present. He may or may not have attained a healthy, positive philosophy of living which makes his life creatively contagious. Perhaps he is developing such a new system of values but, being unsure of its effectiveness and desiring to protect them from his own value system, he divorces this quite successfully from his relationship to the patient or analysand.

Suppose the analysand is a young psychiatrist³ who needs help in resolving a neurosis or wants an analysis as part of his preparation as a psychotherapist. The analyst joins him in a cooperative effort to understand himself well, including his innermost needs and motivations. Really, the process began long ago. In college he began to reject parts of the parental and community value system, although suffering pangs of guilt along the way. So painful did the struggle become in medical school that the basic conflict between values was repressed. A new value system with generations of tradition and all of modern medical science as its supporters was substituted. A system of treating illnesses was developed in which the doctor became the authority, thus usurping for himself the authoritarian role which he had resisted in others in his development. The needs of people keep crashing into this mechanical system, but, to keep old needs of his own from being reactivated, he becomes calloused and even bitter against the value system which the patient won't give up for that proffered by the physician. This, along with exposure to psychosomatic literature and a gnawing hunger to understand and be comfortable with himself, leads him to specialize in psychiatry. Here again he is caught in a struggle between the authoritarian, organically based medical

² *Op. cit.*, p. 32, in quoting his friend about the "scientific" contention that moral convictions and other values are a mere by-product of historical circumstances; that they are mere facts not transcended by value as a principle in itself.

³ The dynamics would be only slightly different were he a psychologist or some other clinically trained professional person.

Perpetuation of Non-Value

RUTLEDGE

training and the theory of psychogenic origin of certain illnesses.

Let's say that the same discomforts as outlined above lead him to undertake a psychoanalysis. It is natural that the analysis should lay bare his early development and conflicts, along with hangover, unresolved emotions and dated motivation. The repressed struggle over values is activated and in a tremendous effort at expurgation he drags forth his old values, discovers their meaning, analyzes them away and leaves them beside the couch. The psychoanalyst has participated in this with him, laying bare with a skillful psychic scalpel the self-protective mechanisms. Gradually the analysand begins to feel free of encumbering ties from the past.

This is a crucial stage. Repeatedly analyses can be seen ending at this point. He is a new person and is cagey about entanglements with new values which might prove as tyrannical as the old. The likelihood is that he has identified quite strongly with his analyst and, mistaking the "negative" analytic work for the analyst's way of life, is glad to level off with the attitudes he thinks the "old man" lives by. Another possibility is that if the mature analyst seeks to move the analysand on into consideration of a new philosophy of life, the growing psychiatrist feels threatened by those new limits and rebels against this stage of work, fleeing into the new-found safety of "the analyzed." Thus, in him, the establishment of a new way of life is characterized by "non-value." From the standpoint of the analyst, he may have gone no further himself and not know how to make the client aware of the need to proceed; he may assume that his role is to "take care of the analysis, leaving integration to occur spontaneously"; he may believe that the growth process will take care of

itself now that the blocking neurosis has been resolved.

All too often the new growth process is barely under way in the patient; the neurosis has been understood but not removed; and integration may occur all too quickly. Energy is expended in defending the new way of life which is characterized, if not by an absence of values, by the failure to deal openly with values and to develop a positive philosophy of life. Life becomes "Nothing But," in the words of Kohler, as a negatively oriented system of therapy becomes the one and only philosophy.

Feeling unable to relate to his family—who continue to adhere to the old values or have been made miserable by his parroting of the analytic sessions—our psychiatrist may neglect them under the guise of his loyalty to the Hippocratic oath. In addition to what this does to the wife and children, it leaves *him* without the most valuable source of love and affection. Starved and drained dry by the demands of patients, he can become a victim of the "non-value" state. In most cases there is a good chance that life will teach him a thing or two, that in treating his patients he will treat himself and grow into a more mature and positively oriented person.

But professional life has not been standing still during this time. He has continued seeing patients in intensive psychotherapy and, if trying to qualify as a psychoanalyst, has been doing analysis under the control of his own analyst or another teaching analyst. Numbers of patients, many of them younger psychiatrists, psychologists and other counselors in training, have come under his care while he was his most "negative" self. It is only natural that the awareness of his own conflicts should help him spot similar ones in them, and the method of treatment likely will be closely akin to that being learned through his own

analysis. Because the treatment of his patients tends to be of shorter duration and therefore more directive than what he is experiencing, and because he tends to hide himself as a person, they get an even more "non-value" orientation than he. This can lead to basic rejection of *all* the old ways as associated with illness or immaturity, which, since there isn't time for thorough working through, quite often is accomplished by repression. What results may be more disturbing than living by any one system of values. The conflict between the repressed old and the new non-value system creates guilt and resultant tension. The tension is felt as a threat of recurrence of the old symptoms and the new way is propounded with a vengeance.

While the young professional person of whatever discipline is in therapy he is all the while working with patients who may in turn identify with the scientific, liberated "air" they feel about their therapist, mistaking what they don't know about him—or what he doesn't possess, or the vacuum in which he lives, or an immature level of development—for the real life to which they should aspire.

The tendency to identify with one's therapist or with the discipline he represents is reenforced by the hierarchy of inadequacy feelings found among psychotherapists and among average people, somewhat according to required years of therapeutic training. The parent feels inadequate in comparison to the teacher and minister, who in turn feel inadequate to the psychologist. The psychologist and social worker feel inadequate to and increasingly strive to be like the psychiatrist. The young psychiatrist strives to be like what he thinks an older psychiatrist or psychoanalyst is like. An occasional psychoanalyst feels inadequate to God.

Seriously, when this pattern prevails, and

each specialist, along with the next up the line, has a negative orientation to therapy and to life, a "non-value" system of values may be perpetuated from generation to generation of psychotherapists.

Clear-cut illustrations of the resultant confusion have been seen in several clergymen who underwent analysis whether for health or professional reasons. Many theological students who are preparing for pastoral counseling wisely seek intensive psychotherapy for themselves. Most of them turn to the young psychiatrist or analyst in training because they can afford only the smallest fees and his schedule will admit them. Usually they quickly discover that much of what they have believed is based upon magical, infantile projections and upon the compulsions to conformity exerted by the family and by the local church. Therapy threatens to destroy their whole way of life, including the career for which they have spent years in preparation. Some terminate therapy prematurely, while others try to maintain both a "new" and an "old," a "scientific" and a "religious" orientation. Others change professions. Fortunate indeed is the one who finds a therapist who will not settle for blanket rejection of the old faith or way of life, but encourages the discovery of principles which apply in all phases of life.

A medical man, Dr. A, who came for marriage counseling, is a case in point. He had been married 13 years and had three healthy children. He was a top man in his specialty and in the social directory. He was sick of marriage and parenthood, and felt medical practice had little to offer and life not much more. He felt alone and yet couldn't accept friendly advances from either men or women. He blamed medical practice and his wife for the loss of all the real friends he felt were his before marriage. With much exploration he came to see that

Perpetuation of Non-Value

RUTLEDGE

his wife was not responsible and that he had merely used the caduceus to justify the hollow existence he had experienced. He clearly dated his "loss of faith" to his 2-year analysis and his resultant determination to live "an absolutely scientific life." At that time he had felt friends merely were opportunities toward whom to express possible homosexual wishes and love was "just sex." The inability to resolve possible latent homosexuality, and the subsequent fleeing from closeness to both sexes, along with rejection of his early rigid religious training, left him a lonely man indeed.

While working with Dr. A the therapist was discussing with an old physician, who had been in the city for years, a now famous and effective psychoanalyst, Dr. Z. The elderly physician said: "Just think—I remember when I stopped sending patients to Dr. Z. He had been a brilliant young psychiatrist but for about two years while he was completing his training analysis I stopped referring anyone to him. Without exception my patients got worse under his care."

Suddenly the therapist remembered that Dr. Z had analyzed Dr. A, the current patient. Out of curiosity, he asked if the old physician could date the years when Dr. Z was seriously upsetting his patients. He could quite definitely. It was the same 2-year period during which he was analyzing Dr. A.

This illustration as stated without all the facts can be picked to pieces, but taken even partially at face value it illustrates the effect of perpetuating a "non-value" orientation to life.

Recently an outstanding psychoanalyst was discussing "the inability to give of oneself and to love within the therapeutic relationship" which often is camouflaged by insistence upon a position of pseudo-objectivity. He said: "For my original

analysis I chose one of the best trained analysts in the world. He knew his stuff, but what a cold fish! Later I realized that something serious had happened to me, or maybe it was something which had not happened. I reentered analysis, but this time with a mature, comfortable, loving, giving person. In this relationship I became what I am; there I learned to live and to love."

Again let it be said that this paper is an overdramatized picture to call attention to a professional malady. There are many major exceptions, as evidenced by recent formal discussions of value. A few psychoanalysts are philosophers in their own right, healthy ones at that. They are attacking this problem by stimulating trainees to a study of philosophy and other great literature, challenging them to a healthy self-fulfillment which will produce effective psychotherapists. Perhaps the second best corrective is calling to the attention of those therapists yet in training, and those currently practicing, the stunted state of development in which they may find themselves. The hope is that their personalities may be reopened to growth and that they in turn may challenge their trainees to a practice of psychotherapy which is concerned with the development of a meaningful, autonomous system of values, whether religiously or scientifically conceived, along with the elimination of outmoded and hindering codes which determine feeling and conduct. In the meantime, the practitioner can see to it that the patient has an equal opportunity to explore the value realm of life along with other areas. Perhaps the area of life felt to be most taboo today, whether in conversation with friend or therapist, is religious belief.

A therapist may realize that he cannot

deal objectively with such areas as value, religion and *Weltanschauung*, or that the therapeutic relationship is ending before the patient begins to grow a more positive way of life. At least he can see that the patient becomes aware of the therapist's interest in this part of his life. Sources of referral can be utilized, and the patient can be challenged to continue working at his growth after therapy is ended. The

average psychotherapist well might make greater use of the family life educator, the clergyman and other well-trained, mental health oriented resource people to continue stimulation of growth in the patient during and particularly subsequent to therapy. This would prevent the relapse of many patients and would encourage the translation of insight into a healthier life for self and for the family.

make
the
mental
continue
during
therapy.
many
transla-
the self

WILLIAM L. PELTZ, M.D.

MARTIN GOLDBERG, M.D.

A dynamic factor in group work with post-adolescents and its effects on the role of the leader

A program of modified group therapy, with 4th-year medical students as the members of the group, has been conducted during the last four years at the Medical School of the University of Pennsylvania and has been described elsewhere (9, 10). The group experience program is an adjunct to the regular program of 4th-year teaching in which the students conduct psychotherapy under close supervision with outpatients in the psychiatric clinic of a general hospital.

Most of the groups have been conducted on an elective basis, although the members of several have been assigned without being consulted beforehand. Each group develops its own goals and methods of procedure. The purpose of the program in general, however, has been defined as follows: "To have the members of the groups come to understand themselves and each other better

through experiencing and examining their reactions to one another and to the leaders. This experience aimed to help them develop awareness of their feelings, attitudes and mechanisms of defense. This gain in self-awareness would lead to greater objectivity, thus enabling them to understand and treat their patients more effectively."

Each group experience, as they are called, takes place once a week for 18 weeks.

Most of the members of these groups, being in their fourth year of medical school, were in their middle or late twenties. One might assume that, having passed well beyond the period of adolescence and of adolescent revolt against authority, the

Dr. Peltz is an assistant professor of psychiatry and Dr. Goldberg an instructor in psychiatry at the University of Pennsylvania School of Medicine.

members would no longer be involved in a struggle for independence and that emancipation would have ceased to be an important or central concern and issue to them. Such, however, was not observed to be the case. In actuality, the relationship of the members to authority figures was the central or most significant dynamic factor in all of the groups in the program.

This possibly obvious finding has led the authors to a consideration of the process of emancipation of the individual personality. In our fairly complex society the transition from the dependent state of interpersonal relationships characteristic of infancy to the true interdependent state desirable in adult life is a long and often tenuous process. It is generally conceived that life proceeds through the absolute dependence of intra-uterine existence; the great relative dependence of infancy; the considerable dependence but emerging independence of childhood; to the conflictual period of marked struggle for greater independence characteristic of adolescence; and finally to the independence, or more properly, the interdependence of mature, adult life.

To get along successfully in our highly competitive society today many young people desire college, graduate and even post-graduate education. Hence, the state of dependency upon family often is prolonged considerably beyond the period of biological adolescence or chronological adolescence, the latter usually being thought of as corresponding roughly with the teen years. Whereas one might ordinarily think of maturity as following immediately upon adolescence, with one of its characteristics being a state of independence or at least freedom from excessive dependency, in actuality the process of emancipation is not resolved when the period of biological adolescence ends. Hence, it is suggested that following the period of adolescence in the

schema of the maturation and emancipation process we might think of a period which can be referred to as post-adolescence. Blois (3) has considered the subject of "prolonged adolescence," describing it as a pathological syndrome. Reserving the concept of prolonged adolescence for those clearly pathological situations such as Blois describes, we suggest that in our society post-adolescence is a normal phase in maturational development, particularly for males.

Maturity in terms of personality emancipation is reached when a person has sufficiently mastered his dependent needs to be able to effect a really meaningful end to the real and/or fantasy authoritarian relationship with parents and parental figures and replace it by a democratic, interdependent relationship with the assumption of full responsibilities.

It should be pointed out that the emancipation conflict exists on two levels: the struggle on the external level with parents, teachers and society and the struggle on the internal level which is fought within the individual against the still-persisting dependent needs (8).

Adolescents demand a greater degree of independence and more privileges than their parents feel they are ready to assume or than the parents are willing to give them. This is often because the parents feel that the young people have not yet shown sufficient evidences of assuming responsibility to warrant granting the desired privileges; at other times it is because parents cling to their children, not wanting them to grow up or become independent. In addition to this external struggle, however, adolescents experience an internal conflict in that they are struggling to grow up and free themselves from the strong dependency needs which they are still experiencing.

During post-adolescence the external and

Group Work with Post-Adolescents

PELTZ AND GOLDBERG

internal conflicts are still going on but they have changed in form. The external struggle or revolt against restrictions and of seeking privileges no longer exists. The victory has been won in these respects. There are still external factors which lead to conflicts, however, for some post-adolescents. For example, some young people still have to depend on their parents for financial support; some may still have to live at home while working or obtaining graduate education and some may have taken on in-law problems.

The picture regarding the internal conflicts, too, has changed. The dependency needs are no longer as strong as they were during the teen years and the young person is now ready to develop more mature relationships with parents and other authority figures. With the lessening of dependency needs, the post-adolescent begins to relate himself to others in a manner that genuinely challenges autocratic structuring and presses toward a really equal relationship.

Reflections of feeling stemming from both the external and the internal conflicts of adolescents and post-adolescents are experienced in group work where they largely shape the relationship of the members to the group leader. In the groups of medical students on which this report is based the transference of unresolved oedipal feelings, the struggle for emancipation from old ties to authority figures, and the seeking of solutions through the finding of more mature relationships were observed. These were seen in the form of direct or indirect expressions of antagonistic feelings toward medical school, the faculty, various teaching programs in the school including the teaching of psychiatry, the group experience program and the leaders of the group itself. As has been noted in other groups (2, 4, 6),

members of the student groups tended to have their own expectations of the leader from the very beginning of the experience and also tended to fall into subgroups of "dependents" (those demanding openly that the leader gratify their needs) and "anti-dependents" (those protesting that the leadership was all wrong and could not possibly help the group).

In functioning as leaders, the authors allowed these post-adolescents complete freedom of expression, which eventually resulted in an open revolt against their authority, sparked by the "anti-dependents." This revolt was quickly followed, however, by the emergence of a state of interdependence and real group unity as more and more of the group members began to assume partial responsibility for the working leadership. It was the authors' impression that this emancipation from the leaders was the most significant experiential gain in the brief time of the group experience's duration. As others have pointed out (2, 4, 6), it appeared that the expression of hostility and revolt against the leader was a necessary and healthy aspect of the process of maturation within the groups, as it is within the lives of individuals.

It is generally accepted that group therapy (as well as individual therapy) should be conducted differently for adults and for children because of differing states of development and needs. Similarly, it is being suggested in this paper that because of certain differences in the maturation process, and therefore in emotional needs, group therapy requires a somewhat distinct approach in post-adolescents as opposed to adolescents.

In spite of their outward rebelliousness, adolescents still need their parents to set limits and restrictions and to satisfy their dependency; and in therapy they require

this similarly. The authors and others (1, 5, 11) have found in treating adolescents that some limits must be set and that the therapist cannot divest himself of all connotations of authority without risking a really chaotic situation. Permission and encouragement of growing independence and maturation are essential, but the therapist functions, consciously or unconsciously, as a kind, understanding and accepting parent. As such he is really a benign authority figure. In group therapy with adolescents the leader has much the same function and must still be very aware of the need to set limits. As Josselyn (7) has noted, "The adolescent looks for identity in the structure of his own age group but his own age group is as fluid as he is. It offers support to his ego, but it is, at best, a tottering, unstable brace." By maintaining his role as the good parent substitute, but always the leader, the therapist offers adolescents a new experience and one which permits identification, maturation and growth in the group. If the therapist should not assume these roles, the group experience could be nontherapeutic or even traumatic, since every member of an adolescent group has marked dependent needs and an absence or overthrow of the leader would result in an untimely and abrupt frustration of this dependency.

We believe that with groups of post-adolescents the rôle of the leader can and should be different. Although the leader will sense conflictual fantasies of himself as a parent-figure in the post-adolescents, he must recognize their readiness and need to emancipate themselves fully and to develop a new and more mature relationship with the leader and with authority figures in general.

Whereas in adolescent groups the anti-dependent revolt might prove to be devastating to the members if the leader did not

maintain control, the leader of groups of post-adolescents can and should permit this revolt to occur since the group is ready for it and can proceed to establish democratic interaction thereafter. In Foulkes' terminology (4), the leader can "let it happen. . . . He does not step down but lets the group in steps and stages bring him down to earth. The change which takes place is that from a leader of the group to a leader in the group. The group, in its turn, replaces the leader's authority with the authority of the group." When this last occurs, a mature relationship of interdependency within the group has been achieved. Most of the members have solved the external rebellious aspects of their adolescent struggle and have progressed sufficiently internally (with their dependent needs) so that they are not only able to resolve their own relationships to the leader on a fairly mature level but are also able to help the occasional rebellious member of the group to work through his problems. Hence, the leader can allow the efforts to displace him to proceed unhampered with full confidence in the group's ability to establish a democratic interdependence.

It is hoped that leaders of adolescent and post-adolescent groups will be better able to conduct their groups effectively if they keep these varying dynamics in mind.

SUMMARY

In 20 group experiences with medical students, who are in the post-adolescent stage of the maturation process, the relationship of the students to authority and authority figures was observed to be the most significant dynamic factor.

On the level of internal conflicts, post-adolescents are not struggling against dependency needs so much as adolescents are; and on the level of external conflicts they are no longer engaged in fighting parental

Group Work with Post-Adolescents

PELTZ AND GOLDBERG

restrictions. Post-adolescents are evolving more mature relationships with authority figures on both internal and external levels. Reflections of feelings stemming from external and internal conflicts were observed in the group process. It is suggested that because of their differing levels of development and therefore differing needs post-adolescents in group therapy should be handled differently from adolescents. Leaders of adolescent groups, for example, when anti-dependent revolt occurs, must maintain a benevolent but appropriately firm authority role, while fostering ego-strength and development. Leaders of post-adolescent groups, on the other hand, should be more relaxed and permissive. They can and should permit such revolts to occur since they are mostly limited to a few members and will be handled by other members. Maturation with the development of interdependency will thereby be enhanced and the group experience will have been more meaningful.

BIBLIOGRAPHY

1. Ausubel, D. B., *Theory and Problems of Adolescent Development*. New York, Grune and Stratton, 1954.
2. Bion, W. R., "Experiences in Groups 1, 2, 3, 4, 5," *Human Relations*, Vols. 1-3, London, Tavistock Publications, 1947-49.
3. Bos, P., "Prolonged Adolescence," *American Journal of Orthopsychiatry*, 24(1954), 733.
4. Foulkes, S. H., "Concerning Leadership in Group-Analytic Psychotherapy," *International Journal of Group Psychotherapy*, 1(1951), 319-24.
5. Hacker, F. J. and E. R. Geleerd, "Freedom and Authority in Adolescence," *American Journal of Orthopsychiatry*, 15(1945), 621-30.
6. Hollister, W. G., "The Risks of Freedom-Giving Group Leadership," *Mental Hygiene*, 41(April 1957), 238-44.
7. Josselyn I., "The Ego in Adolescence," *American Journal of Orthopsychiatry*, 24(1954), 230.
8. Levy, J. and Ruth Munroe, *The Happy Family*. New York, Alfred A. Knopf, 1938.
9. Peltz, W. L. and others, "A Group Method of Teaching Psychiatry to Medical Students," *International Journal of Group Psychotherapy*, 5(1955), 270-79.
10. Peltz, W. L., E. H. Steel and S. Wright, "Group Experiences with Medical Students as a Method of Teaching Psychiatry," *American Journal of Orthopsychiatry*, 27(1957), 145.
11. Schulman, J., "Modifications in Group Psychotherapy with Antisocial Adolescents," *International Journal of Group Psychotherapy*, 7(July 1957), 310-17.

Culture and mental disease

Since it has been proved that the frequency of mental diseases is generally in direct proportion to civilization and its accompanying social collisions, it might be surmised that these diseases are extremely rare on the Faroes, inasmuch as civilization has certainly not attained a high degree there, and the social collisions so agitating to the mind, under the patriarchal conditions which prevail, are proportionately very few. But on the contrary, there is hardly any other country, or indeed any metropolis, in which mental diseases are so frequent in proportion to the number of people as on the Faroes.—Peter Ludwig Panum, "Observations Made During the Epidemic of Measles on the Faroe Islands in the Year 1846."

EPHRAIN H. ROYFE, M.S.S.W.

A low-cost psychotherapy program for Essex County, N. J.

This article describes the development by the Mental Health Association of Essex County, N. J., of an out-patient treatment facility for marginal-income families. This achievement was made possible through the cooperation of 32 psychotherapists, utilizing a multi-disciplinary approach.

Essex County, located in the north central region of New Jersey, has a population of a million people divided about equally between the Newark industrial area in the east and the wealthier suburban region in the west. Although there are sizable areas in need of urban redevelopment, the county

nevertheless ranks 11th in the nation in wealth with an estimated purchasing power of \$7,940 per family.

As impressive as these figures may appear, the number of requests for psychiatric assistance from families who cannot afford private care has increased each year as the educational programs and publicity emanating from our Mental Health Association have made them aware of their need for help. Our Essex County chapter has adopted the philosophy that community mental health education without mental health resources can lead only to an increase in anxiety among those recognizing that they have problems. The validity of our philosophy—and the dangers of denying it—became only too clear to our staff during the last two years when our referral and information department received more than

At the time he wrote this paper Mr. Royfe was executive director of the Mental Health Association of Essex County, N. J. He is now director of programs and services for Big Brothers of America, with headquarters in Philadelphia.

A Low-Cost Psychotherapy Program

ROYFE

1,400 requests for psychiatric assistance. The majority came from families in need of out-patient services and unable to afford private care.

The out-patient psychotherapeutic resources for adults in our community consisted of a traveling clinic, which made available 65 hours of treatment a week, and two general hospitals, both located in Newark, which made available an additional 23 hours of treatment to the residents in the area.¹ The caliber of services that these hard-pressed agencies offered to a patient varied from interviews lasting from five minutes to the traditional fifty minutes; similarly, the frequency of visits ranged from one interview a week to one interview in several months. The bleak fact that some clinics were encountering resistance from psychiatrists who were loathe to devote half-days to an operation which was frustrating and unrewarding further aggravated this desperate shortage of facilities.

The Mental Health Association of Essex County was deeply concerned with this overflowing demand and with the fact that patients had to wait many months for even these meager resources. We were further concerned because the caliber of care received by a person in psychotherapy was too often predicated on his ability to pay. Although many of the psychotherapists in the community spent considerable time in serving patients in marginal economic circumstances, the fact still remained that a disproportionate number of individuals in need of psychotherapy at a reduced fee were not obtaining the best possible services.

The Mental Health Association therefore decided to develop a program that would utilize the talents of competent psychotherapists in the community. In doing so, it sought to make the best possible use of their precious time, taking steps to assure through adequate screening that only those accessible

to out-patient psychotherapy and financially unable to afford the service would receive consideration. This low-cost psychotherapy plan, conceived as a demonstration project for a 3-year period, was designed to operate with a minimum expenditure of money, time, effort and building maintenance. Intrinsic in its philosophy was the fact that it aimed to give the highest quality of service to people within a certain income bracket, on a sliding scale in accordance with their ability to pay.

The plan was developed in conjunction with a group of psychiatrists, psychologists, and psychiatric social workers, and is under the chairmanship of a prominent psychiatrist residing in Essex County. Within the last year the plan has received the endorsement of the professional societies. Currently 15 psychiatrists and 17 psychologists are participating. Only the generosity of these professionals and their donation of time and effort have made this project feasible.

All applicants for out-patient psychotherapy are received in our Mental Health Association office and are directed to our psychiatric social worker. He is attached to our low-cost psychotherapy plan and serves as its co-ordinator. Where indicated, he arranges psychological testing, calling on the services of our panel members; where a complete psychological workup is required, the psychologist performing this service receives a modest hourly fee in keeping with the intent of the plan.

Once it is determined that a patient is able to use the services of a therapist and is otherwise eligible for help under this plan, he is accepted for treatment and assigned

¹ The Veterans Administration maintains a regional office in Newark but restricts its out-patient psychotherapy to those with service-connected psychiatric disability.

after clearance with the therapist. Appointments are arranged by the social worker at the convenience of both the patient and the therapist. Therapy is conducted in the private offices of the psychotherapists, thereby enabling the professional who is contributing his services at a reduced fee to spend as little time as possible in traveling away from his office. An additional plus factor in this arrangement is the feeling by many that the private office atmosphere is essential for obtaining the best results.

Each therapist in the plan receives \$5 an hour for his services, and none is permitted to contribute more than five hours a week. Patients who are accepted by the plan pay a maximum of \$5 a visit and remit their fee directly to the therapist. When the patient cannot afford the fee, the Mental Health Association subsidizes his treatment up to the limit of \$5 an hour. At least every three months (and more often if it is thought advisable) the therapists provide the association with a formal report on each patient's progress. These reports are reviewed by the original screening psychiatrist as well as by the co-ordinator of the plan. Psychiatric consultation is available to all non-medical therapists during the course of treatment, and in accordance with established practice the individual therapist, when he considers it appropriate, will use consultation (which is again sponsored by the low-cost psychotherapy plan). In addition to this consultation, it is anticipated that within a short time regular seminars and group discussions of case material will be instituted.

Closer relationships between the therapists and the examining psychiatrists is also encouraged and both disciplines feel they can gain from this form of collaboration. Eventually the plan may take on added teaching value for the participants.

Although the plan operates under the direction of the board of directors of the Essex County Mental Health Association, it is supervised by a professional steering committee composed of leading psychotherapists and social workers in the community, the majority of whom are themselves panel members. This committee screens all applications for panel membership and only well-trained and experienced psychotherapists capable of functioning with a high degree of independence and meeting the professional standards that have been formulated by the committee are eligible for membership.

The plan, as outlined above, went into operation on September 9, 1957. Since then approximately 75 clients have been placed in therapy. They have used 100 treatment hours. They range in age from 16 to 50; about 90% of the patients accepted for treatment are under 40. Most are married, have an average of two children and a mean gross family income of \$4,200 a year. Although our sliding scale is between \$2 and \$5 for each treatment hour, a great number of the patients are able to pay the maximum \$5 fee. Consequently, the amount of subsidization that has fallen upon the shoulders of the Mental Health Association is comparatively little. The total amount budgeted for the project is \$16,700 and covers the salaries of a social worker, secretary, office expenditures and subsidization of therapists. At present, the plan receives 50% of its support from the state under the Community Mental Health Services Act.

It should be borne in mind that this plan is a pilot project of the Mental Health Association of Essex County and that appropriate changes are constantly being made in accordance with the professional recommendations of the advisory committee following a suitable period of study. It is rec-

A Low-Cost Psychotherapy Program

ROYFE

ognized that the program is not a panacea for the marginal-income group, but in the absence of other out-patient clinical facilities in our county, it offers a sizable proportion of additional resources in a dignified atmosphere conducive to good psychotherapy. The potentialities of this

plan—particularly in contrast to that in other social agencies spending \$20 or more an hour for psychotherapy—will bear careful reviewing. We hope within a short period of time to be able to describe more fully the therapeutic results of our program and the patients we are serving.

ROBERT GIBSON, M.D., Ch.B., D.P.M.

Changing concepts of mental deficiency

The past few years have witnessed a pronounced upsurge of interest in all aspects of mental deficiency. Older concepts are being modified, newer ideas are crowding in, and the entire subject is in a state of flux. This fluidity is reflected most fundamentally in uncertainties over terminology, definition and incidence.

The tendency to avoid the use of traditional expressions for mental deficiency and for the grades of mental deficiency has become increasingly noticeable. The reason would seem to be that these expressions are thought to have become identified with an aura of hopelessness out of keeping with the changing attitude towards mental defectives. Nevertheless, until a newer terminology wins general acceptance there is at

present a risk of confusion from the number of conflicting terms competing for priority.

Suggested substitutes for "mental deficiency" range from "cerebral paucity" (1) to "severe subnormal personality" (2). The latter has behind it the authority of the newly-issued report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency 1954-1957. The report indeed comes out strongly on the side of change. Thus, with regard to severely subnormal patients, or patients with severely subnormal personality, it states: "This term should be used when the general personality (covering intelligence and temperament together) is so severely subnormal that the patient is incapable of leading an independent life. Severely subnormal patients include those at present classified as idiots and imbeciles and some of those now classified as feeble-minded (that is, morons)."

Dr. Gibson is clinical director of the Manitoba School in Portage la Prairie, Manitoba.

Mental Deficiency

GIBSON

The report goes on to say: "The terms 'idiot' and 'imbecile,' and the terms 'mental defective' and 'defective' should no longer be used." The tendency to get away from the use of the term "mental deficiency" is more marked still in those quarters where the employment of the expression "social inadequacy" is put forward as an appropriate synonym.

A considerable measure of popular acceptance has been accorded the terms "educable" and "trainable" in place of "moron" and "imbecile," whilst "totally dependent" or "extremely retarded" have found favour as substitutes for "idiots." Some time ago Kanner (3) suggested the term "absolute" to include idiots and imbeciles, reserving the term "relative" for morons, on the principle that the limitations of the latter are related to the standards of the society around. Certainly, a term like relative feeble-mindedness undoubtedly highlights one of the leading characteristics of the moron grade, constituting as it does 75% of all defectives in the community. It is possible, however, that later users of the term may have done disservice to the concept by conveying the impression that relative deficiency is of comparatively minor significance in relation to the absolute deficiency of idiots and imbeciles. When it is recalled that up to a century or so ago the obvious defectives were idiots and imbeciles, and that morons subsequently assumed prominence through their inability to meet increasing complexity, the relativity of their defect can be more fully appreciated. But even if the comforting view is adopted that theirs is merely a relative disability as the result of Western emphasis on efficiency and industrialization, the problem is in no way lessened, more especially when it is becoming increasingly clear that industrialization is taking root in hitherto untouched areas of the world.

Similar uncertainty prevails with regard to the relative use of the terms "mental retardation" and "mental deficiency." At one time they were used more or less synonymously but the trend latterly has been to differentiate more clearly between them. "Mental retardation" is generally used with reference to all cases with an intelligence quotient under 70. Employed in this fashion it includes two or more subgroups. It includes, for example, probably the bulk of mental defectives, where intellectual retardation is associated with social incompetence. It also includes the subgroup characterized by intellectual retardation without social incompetence. This section is variously known as mentally handicapped or educationally defective, which again is quite distinct from educationally retarded or merely backward. By some writers the term "mental retardation" is applied exclusively to cases of intellectual retardation without social incompetence, although its use here has been criticised on the ground that retardation in the educational sense need not necessarily denote retardation in the psychological sense.

Whilst a simple dichotomy of this nature is fairly common there are more elaborate subdivisions which, useful though they may be in practice, nevertheless add appreciably to the risk of semantic confusion. Thus one writer (4) subdivides the concept of mental retardation into five categories: mental deficiency, defined as a general inadequate adaptation; mental defectiveness, or a scattered impairment of abilities; mental deficit, or attention and concentration defects in brain injury, for example; mental inadequacy, or borderline cases induced by cultural, social or educational factors; and, for good measure, pseudofeeble-mindedness, which is defined as an apparent deficiency on the basis of emotional and intellectual disorders.

If we should for the present regard the term "mental deficiency" as legitimate verbal currency we still have difficulty in finding a generally acceptable definition. The English legal definition in the Act of 1929 defined it as "a condition of arrested or incomplete development of mind existing before the age of 18 years, whether arising from inherent causes or induced by disease or injury." A definition quoted by the Scandinavian writer Kemp (5) is more explicit in defining it as "a state of incomplete development (of mind) of such a kind and degree that the individual is incapable of adapting himself to the normal environment in such a way as to maintain existence independently of supervision, control or external support." In the Wood report (6) a mental defective was defined simply as "one who by reason of incomplete mental development is incapable of independent social adaptation." Extreme emphasis on defect of behavioural adaptability as the main criterion of mental defect distinguishes the view propounded by Delay and colleagues (7) that social incompetence in the presence of a good intelligence quotient may be really a camouflaged mental deficiency.

Meyer-Gross (8), on the other hand, uses the term "mental deficiency" to signify "a condition of subnormal mental development present at birth or in early childhood, and characterized mainly by limited intelligence." Limited intelligence as the cardinal feature is also stressed in the United States, where, for example, the statistical manual for institutional use defines a moron as "a mentally defective person usually having a mental age of 8 years or upwards, or if a child, an intelligence quotient of 50 or more, with a quotient of 69 as the upper limit for a diagnosis of mental deficiency."

Then there is a physical criterion of mental deficiency which under some circum-

stances may be the most applicable. As Penrose (9) has pointed out, it is fairly obvious, quite apart from the application of social and intellectual criteria, that an untreated cretin or phenylketonuric will come within the scope of mental deficiency.

Finally, some workers take up the position that there can be no firm diagnosis until maturity. This, for example, is the stand taken by Doll (10). In this view the more conservative term "potentially mentally deficient" is suggested for children who have not matured.

Lack of complete uniformity is therefore still obvious in deciding what constitutes mental deficiency. Whilst it is more usual to regard intellectual retardation as the cardinal feature, with social incompetence as a manifestation, nevertheless for others the kernel of the problem is social incompetence, not necessarily accompanied by reduced intelligence. On the whole, however, it is fairly widely conceded that both intellectual retardation and social incompetence are necessary, the emphasis placed on each component being subject to variation. What emerges is a broad basis of agreement that the essential manifestations are intellectual retardation and social incompetence from an early age, with perhaps a corollary that the conditions which lead to the underlying arrest or incomplete development of mind may also manifest themselves physically. The mental defective may consequently attract attention because of his lack of intellectual progress, his social incompetence, and perhaps the distinctive physical picture he presents. Thus he may show himself unsuitable for education under the ordinary educational system, he may prove quite incapable of managing himself and his day-to-day life with ordinary common sense, and he may at the same time vary physically from apparent normality to the abnormality of mongolism or cretin-

ism. Because of the degree of his deficiencies he is in need of care, supervision and control.

Closely connected with the concept of mental deficiency is that of pseudodeficiency or pseudofeeble-mindedness. This latter term has acquired considerable vogue in recent years. It is employed with reference to individuals labeled mentally deficient at one period of their lives but who later are not so regarded. The inference is then drawn that these individuals were not mentally defective in the first place but only pseudofeeble-minded. The diagnosis is therefore made in retrospect. Like "mental deficiency" the term is subject to a number of interpretations. Thus it has been interpreted as meaning a state of delayed maturation. However, as McCandless (11) has pointed out, persons who are defective because of delayed maturation just cannot be differentiated by current procedures from those of the same tested level who are defective from other causes.

Another view is that recently propounded by Benton (12) that pseudofeeble-mindedness should be regarded actually as mental deficiency of atypical etiology. This may be of a physical nature, as in visual or auditory handicap, or motor deficit of cerebral palsy. It may be psychological, where emotional disturbance is thought to inhibit the acquisition of basic mental abilities. It may finally be social, the result of unstimulating social or family environment or inadequate schooling. Pointing out that the typical effect of physical or social handicap is a comparatively minor drop in intelligence level, the author speculates that it may be different in the case of children whose intellectual potentialities are reduced from the commencement, or where multiple handicaps occur. In Benton's opinion, pseudofeeble-mindedness may result from either the interaction of a specific handicap

with an intelligence which, though subnormal, is above the defective range, or from multiple handicap in a child of average intellectual potentialities. It need scarcely be stressed in passing that the main effect of social handicap is in the social aspect itself. In this connection the wise handling of a case may well result in the development of an ability to cope with the demands of society, and if this is achieved the mental deficiency in the social sense is reduced or eliminated to a point where the diagnosis is no longer appropriate.

Not infrequently the term "pseudofeeble-mindedness" seems to be employed merely to signify a mistaken diagnosis which has become apparent in the course of time. When it is used in this manner its scope is very greatly increased, although it is certainly open to the criticism that diagnostic errors should not be elevated to the status of a clinical entity (12). Used as a synonym for differential diagnosis it may refer to any one of a considerable range of conditions.

Since mental deficiency is characterized by both intellectual retardation and social incompetence it has to be distinguished from certain states where only one criterion is present, or appears to be present. In actual practice this involves consideration of three separate groups: conditions characterized by intellectual inadequacy alone, specific defects of a visual, auditory or speech nature which may superficially resemble intellectual retardation, and conditions characterized by social incompetence alone (13).

The group where intellectual inadequacy alone is present includes cases of intellectual retardation without social incompetence, who are sometimes referred to as mentally handicapped; cases of dullness; and, since a substantial proportion of backward children, or children with educational retardation, have subnormal intelligence, consideration has also to be given to this class.

Specific defects of a visual nature include conditions like congenital blindness, visual cerebral injury and congenital word blindness; those of an auditory nature take in congenital deafness, high-tone deafness and congenital word deafness, whilst among speech defects are mutism, delayed development and congenital motor aphasia. Where social incompetence alone is in question it may be a matter of delinquency from such causes as maladjustment, adolescent instability or frank psychopathy. In some cases it may be the aberrant behaviour associated with convulsive disorder, and in yet others it may involve actual psychosis.

Some groupings are naturally encountered more frequently than others. A rough guide to their relative incidence may be obtained from cases referred to mental deficiency clinics. Thus of the first 250 cases referred to one group of clinics (14) only 104 were actually defective. Of the remainder the largest number—89 juveniles and adults—fell into the subnormal section. The next largest number—50 cases—made up the section characterized by behaviour disorder of delinquent, convulsive or psychotic type, whereas only 7 cases could be included within the section of specific defects.

The uncertainties in terminology and definition have their counterpart in incidence. The general incidence of mental retardation has been estimated at anything from 10 to 50 per 1,000 of the general population. A recent publication of the National Association for Retarded Children (15) cites an incidence for the United States of 30 per 1,000, specifying that out of every 30 retarded children 25 are educable, 4 trainable and 1 totally dependent. A prevalence study of mental retardation conducted by the Mental Health Commission in Onondaga County, New York in 1953 and 1954 (16) tended to bear out this incidence. It reported that from birth through eighteen

years $31\frac{1}{2}\%$ of the population were mentally retarded. It should, however, be mentioned that the Onondaga County study was of cases reported as mentally retarded, although these reports were not confirmed by clinical study.

In the case of mental deficiency, variation is still more apt to be encountered. In fact, it seems unlikely that any estimate could be found with universal application. Since the ranks of defectives are usually swollen by a proportion of individuals with a mental level above that of the retarded, the number of defectives will naturally vary according to the different criteria in force. Thus in England, which has always underlined the social component of mental deficiency, certification may take in a section with an intelligence considerably higher than the retarded range. Just how high was recently indicated by an investigation of institutionalized defectives in the greater London area. The investigators (17) claimed that half the adult patients certified as feeble-minded (or moron) and placed in institutions were dull rather than retarded, with an average I.Q. of 70.

So far as actual estimates are concerned a commonly quoted figure in the United Kingdom, based on the extensive work done by the Wood Commission in 1929 (6) is 8.6 per 1,000 for the population as a whole. It was left, however, to Penrose (9) to point out the wide fluctuation which occurred when the commission's report was analyzed according to age groups. In the 30 to 39 age group, for example, the incidence was only 5.7 per 1,000, whereas between the ages of 12 and 13 years it reached its peak incidence of 30 per 1,000.

A more recent survey carried out in the eastern health district of Baltimore (18) furnished an over-all incidence of 12.2 per 1,000. Both surveys showed their maximum incidence between the ages of 10 and 14

Mental Deficiency

GIBSON

years, with marked falling-off above and below these ages. Within these age limits the respective figures were 25.6 and 43.6 per 1,000. By comparison the proportions between the ages of 40 and 49 were only 5.4 and 7.4 respectively. According to Penrose, the reduction in incidence following the scholastic period occurred because what he termed the "rigid standards of scholastic environment" no longer applied, whilst the later choice of suitable employment aided adjustment.

The Wood Commission made it clear that its findings represented the number of persons who were incapable of independent social adaptation because of incomplete development of mind, and that they did not include children who were educationally rather than socially defective. Subsequent opinion, however, has tended to regard its estimate of 8.6 per 1,000 as too conservative, and quite possibly the Baltimore incidence of 12.2 per 1,000 may be nearer the mark. Fremming (19), indeed, claims that recent Scandinavian investigations show that 10 to 15 per 1,000 of the population are certifiably mentally defective. Kemp (5), also dealing with Scandinavian material, makes no attempt to form an accurate estimate but contend himself with indicating that what he terms the "true mental defective," as distinct from the mentally retarded, probably constitutes 10 to 20 per 1,000 of the population.

Nevertheless, such estimates relate primarily to cases potentially certifiable rather than actually certifiable, since certification depends on the demonstrated need for care and control. The number of those who actually require to be certified is fortunately much less. It includes certified institutional defectives as well as those certified under guardianship. Here again it is difficult to reach finality. In 1954, for example, in England and Wales there were about 56,000

institutional cases compared to approximately 82,000 cases under guardianship and on licence from institutions in addition to cases under statutory supervision, the total number amounting to practically 3 per 1,000. In the same year, in the same island, there were in Scotland approximately 5,000 institutional defectives and fewer than 3,000 cases under guardianship or on licence from institutions, providing a total estimate of about 1.5 per 1,000.

The provision of purely institutional accommodation is generally based on an estimate of 2 per 1,000 of population, but the degree to which it is allocated between high- and low-grade patients is again subject to variation. Thus, if all low-grade cases were institutionalized the total accommodation would clearly be exhausted by this group alone. However, Penrose (9) estimated that in England and Wales, for example, the institutional population represented 3% of high-grade and 25% of low-grade defectives in the community. Since until recently the tendency has generally been to regard low-grade defectives as primarily a custodial problem, the fate of the remaining 75% assumes some significance.

A partial answer to this question is provided in a report published late in 1957 by the New York State Interdepartmental Health Resources Board (20) concerning the findings of a study made by the research center of the Graduate School of Public Administration and Social Services of New York University. The object of the study was to find out what proportion of severely retarded adults managed to remain outside institutions, and the type of adjustment they made in the community. The group chosen was not representative of all low-grade adults but was principally limited to the section with I.Q. between 40 and 50 who had attended low I.Q. classes in New York. In operation since 1929, these classes had

originally accepted pupils with any I.Q. below 50 but since 1941 had limited their intake to the 40-50 I.Q. range. It was found that out of a total of 2,640 former pupils between 17 and 40 years of age at the time, 26% were in institutions, 8% had died since leaving school, and 66% were living in the community. Of those in the community the bulk spent the greater part of the day at home, and only a third were capable of leaving their immediate neighbourhood and getting around by themselves. About 7% got into trouble, mainly minor offences like vagrancy and peddling without a licence. No fewer than 27% were working for pay. Admittedly most of them obtained their earnings by carrying out simple household chores, but one in three was able to find employment in stores or unskilled work in factories. Of those working at the time of study half earned more than \$20 a week and a few earned up to \$40, \$50 or even \$60 a week. However, the report does not fail to establish the dependence of the group on parents and relatives, whilst a further point that emerges is the increasing demand for services like day-care centers, workshops and recreation centers to assist in retaining them within the community.

These then are some of the trends and uncertainties which are apparent in the sphere of mental deficiency. Though it is obvious that uniform agreement on some fundamental issues still eludes our grasp we have at least a reasonable hope that the rising interest in all aspects of the subject may throw a clearer light on current problems.

REFERENCES

1. Michal-Smith, H., *The Mentally Retarded Patient*. Philadelphia, J. B. Lippincott Co., 1956.
2. *Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency, 1954-1957*. London, H. M. Stationery Office, 1957.
3. Kanner, Leo, "Feeble-mindedness, Absolute, Relative and Apparent," *The Nervous Child*, 7(1948), 365.
4. Tracy, W. H., "Notes on the Concept of Intelligence and the Problem of Mental Retardation," *Delaware State Medical Journal*, 28(1956), 8.
5. Kemp, T., *Genetics and Disease*. Edinburgh, Oliver and Boyd, 1951.
6. *Report of the Mental Deficiency Committee* (Wood report). London, H. M. Stationery Office, 1929.
7. Delay, J., P. Pichot and J. Perse, "La Notion de Débilité Mentale Camouflée," *Annales Médico-Psychologiques* (Paris), 110(May 1952), 615.
8. Mayer-Gross, W., E. Slater and M. Roth, *Clinical Psychiatry*. London, Cassell and Co., 1955.
9. Penrose, L. S., *The Biology of Mental Defect*. London, Sedgwick and Jackson, 1954.
10. Doll, E. A., "Is Mental Deficiency Curable?" *American Journal of Mental Deficiency*, 51(1947), 420.
11. McCandless, B., "Environment and Intelligence," *American Journal of Mental Deficiency*, 56(1952), 4.
12. Benton, A. L., "The Concept of Pseudofeeble-mindedness," *Archives of Neurology and Psychiatry*, 75(1956), 379.
13. Gibson, R., "Differential Diagnosis of Oligophrenia," *American Journal of Diseases of Children*, 83(1952), 151.
14. Gibson, R., "A Survey of Special Types Encountered in Mental Deficiency Clinics," *American Journal of Mental Deficiency*, 58(1953), 1.
15. *Now There is Hope*. New York, National Association for Retarded Children, 1957.
16. Downing, J. J. and E. M. Gruenberg. *Onondaga County, N. Y., Mental Retardation Prevalence Survey* (preliminary report). Albany, New York State Department of Mental Hygiene, 1955.
17. O'Connor, N. and J. Tizard, "A Survey of Patients in Twelve Mental Deficiency Institutions," *British Medical Journal*, 1(1954), 16.
18. Lemkau, Paul, C. Tietze and M. Cooper, "Mental Hygiene Problems in an Urban District" (third paper), *Mental Hygiene*, 26(1942), 275.
19. Fremming, K. H., *The Expectation of Mental Infirmary in a Sample of the Danish Population*. London, Cassell and Co., 1951.
20. Saenger, G., *The Adjustment of Severely Retarded Adults in the Community*. Albany, New York State Interdepartmental Health Resources Board, 1957.

ROBERT S. MORROW, Ph.D.
MARGARET M. KINNEY, M.S.

The attitudes of patients regarding the efficacy of reading popular psychiatric and psychological articles and books

The number of popular books and articles concerning psychological and psychiatric topics is very extensive. Several of these books have been best sellers year after year. This general interest, as noted by publishers, librarians, booksellers and psychologists, is a source of much comment, but few studies deal with the people who read this literature, or with why it is read, or with whether any direct value is derived. The same is true of the literature considering the therapeutic value of books and reading in general—that is, bibliotherapy. In some 500 items listed in the bibliographies of this subject few attempts have been made to determine scientifically such questions as these.

The patients in our hospital—a Veterans Administration general medical and surgical hospital—we felt would be a suitable population in which to investigate some

of these questions, since one finds here a representative cross section of the adult male population.

The opportunity to do the study came shortly after *Life* magazine January 7, 1957, began to publish a series of five articles on psychology. These were used as a central point in our investigation. Specifically, we set up a pilot study designed to answer the following broad questions:

1. Do psychiatric patients in general read more psychiatric and psychological material than nonpsychiatric patients?
2. Do these two groups indicate different kinds or degrees of feelings and attitudes toward such literature?

Dr. Morrow is chief clinical psychologist and Miss Kinney chief librarian at the Veterans Administration Hospital in The Bronx, N. Y.

METHODOLOGY

We designed for simple individual or group administration and evaluation a questionnaire containing 10 questions. These items are presented with the results. The librarians who visit the various wards with the reading material asked patients selected at random to cooperate in filling out the questionnaire. They were present only to help clarify some of the questions or to interview the patient if his disability interfered with writing.

The Veterans Administration Hospital in the Bronx has approximately 1,300 patients. Of these only 150 are psychiatric cases, most of them in fairly good contact with reality. We selected randomly from this group only the open-ward patients—that is, those who were not grossly psychotic or unduly disturbed and whose answers could be considered valid.

Fifty-six such patients answered the questionnaire. Their mean age was 35.9 years with the range from 22 to 59. (Patients over 60 were not used in the study.) Their educational level was at a mean of 11.2 years of schooling with a range from 3 years to 16 (16 years was established as the ceiling even for those with graduate and professional school training). To see whether the length of stay in the hospital had an effect on attitudes, the length of the patient's hospitalization in weeks was obtained. For this group the mean hospital stay at the time of the interview was 12.6 weeks, with the range from 0.5 weeks to 52 weeks.

Of the nonpsychiatric patient population 84 were randomly chosen from the various medical, surgical and rehabilitation wards. This group was composed of the following: 17 paraplegic, 10 surgical, 12 tuberculous, 20 chronic medical, 15 recuperating from medical conditions and 10 dermatological

patients. Taken as a single group, their average age was 38.0 (range from 21 to 60); average education 11.2 years (range from 5 to 16 years); hospital stay 13.2 weeks including the paraplegic patients, 11.1 weeks without the paraplegics. On the whole, using as controls age, education and length of stay in the hospital, the psychiatric and nonpsychiatric groups appear to be fairly similar.

TEST RESULTS

The table summarizes the answers of the two groups of patients to the questionnaire. Since there is a difference in the size of these groups, the results have been made comparable by converting into percentages the responses to each question.

It can be seen that there is great similarity between the groups in answering the first item since about two-thirds of each stated that they enjoy reading books and articles on psychology and psychiatry. In the next item, however, there exists an important difference as to whether they find these helpful or not, with more of the nonpsychiatric group reporting them as helpful. A suggested explanation as to why more nonpsychiatric patients consider this material helpful is that they may feel that this should be so theoretically, whereas the psychiatric patient more likely reports from experience and disillusionment.

There appears to be a basic difference with regard to item 3 in that more of the psychiatric patients seem to be directed to this literature through their own curiosity and search for self-help. The nonpsychiatric patients are somewhat more dependent upon others to make recommendations. The library is a constant source of reference for both groups. As to who recommended the material or other sources of direction, too few patients answered to give sufficient information.

The Efficacy of Reading

MORROW AND KINNEY

Summary of results on questionnaire

ITEM	PSYCHIATRIC				NON-PSYCHIATRIC	
	(Percent Answering Affirmatively)					
1. I do/do not enjoy reading books and articles on psychology and psychiatry	68				67	
2. I feel that articles and books of this kind are helpful/not helpful	72				84	
3. How are you directed toward these books and articles? (answers in percentages)						
	Self	Recommended	Library	Others		
Psychiatric	57	10	17	16		
Nonpsychiatric	49	16	16	19		
4. How much time do you spend in such reading? (answers in percentages)						
		Occasionally	Frequently			
Psychiatric		94	6			
Nonpsychiatric		96	4			
5. Were you interested in reading in this field before coming here?	72				68	
6. Do you intend to continue this interest?	63				66	
7. Does your reading of this type consist mostly of						
	(a) Books	33			31	
	(b) Articles	67			69	
8. Have you read any of <i>Life</i> magazine's recent series of articles on psychology?:						
	(a) None	31			47	
	(b) Some	58			48	
	(c) All	11			5	
9. What did you think of the <i>Life</i> articles?:	89				91	
10. Were any of your personal questions answered by the <i>Life</i> articles?	53				38	

Most of the patients indicated on item 4 that their reading in this area is occasional rather than frequent or regular. There is not much difference between the groups on items 5 and 6, which deal with interest in reading this literature before hospitalization and subsequent to it. However, while the psychiatric group was somewhat more interested initially, they indicate a 9% drop in continued interest, whereas the nonpsychiatric group of patients remain pretty much the same. Two explanations are suggested. One is that the psychiatric patients have not been able to find satisfaction or solution for their problems in the literature, and this drop represents their disappointment. Another

possibility is that these patients are receiving psychotherapy and no longer need outside help or, as sometimes happens, they are requested by their therapists to discontinue such reading so as not to become confused.

Item 7 indicates that both groups read articles much more frequently than they read books. There was a fairly high overlap involving both categories to indicate that there are many who read books as well as articles. This seemed to occur more often for those whose preference was for books and who added comments to show both. There is a substantial difference between the two groups on item 8, which shows that a higher percentage of the psy-

chiatric patients was interested in the *Life* magazine articles on psychology. This is shown by the fact that of the two groups a larger number of psychiatric patients read some of the articles and twice as many were sufficiently interested to read all of them. Of those who read some or all of the series there is no substantial difference between the two groups on item 9 since approximately 90% of both groups expressed positive attitudes. What is more significant is that item 10 showed that more of the psychiatric patients felt that they received answers to some of their personal problems. As a matter of fact, more than half of the psychiatric patients who read at least some of the articles felt this way while only about one-third of the nonpsychiatric group expressed this attitude.

The fairly large difference between those who express positive attitudes in general toward this literature (item 8) and those who state that they derived personal help (item 10) tends to show that these feelings and attitudes are abstractly determined rather than rooted in personal experience. This is exemplified by the patient who remarked that "I, myself, was not helped but I know it's supposed to help you."

At the end of the questionnaire both groups were asked in what respects more information would be wanted, and very few answers were given. This would indicate either that the patients involved in this study regard the literature as already sufficiently complete (which does not seem too likely) or else they do not feel competent to make suggestions. Where suggestions were offered, they most often requested that the material be presented as TV and radio programs rather than in printed form. A few suggested such topics as more information about psychotherapy and psychoanalysis, abnormal psychology, normal behavior and child psychology.

DISCUSSION

The results of this preliminary investigation indicate that while the psychiatric and nonpsychiatric population are not basically dissimilar in regard to their interests in psychological and psychiatric literature, some meaningful differences do emerge.

It can be seen that the psychiatric patients begin with greater interest and curiosity but that more of them express disappointment as far as tangible benefits from their reading are concerned. This does not, however, apply to the *Life* articles on psychology. Here the attitude expressed by those in both groups who had read some or all the articles was very favorable, but the psychiatric patients reported a higher degree of satisfaction or help. This would tend to indicate that books and articles written by experts in the field are more likely to be satisfactory or beneficial.

It is axiomatic that people have different motives for reading. These involve personal motivation as well as intellectual curiosity, literary enjoyment, etc. Of significance is the fact that 70% of this typical patient population borrows books. The reading of psychological literature seems to be in accordance with the general interest in reading—that is, 68% of the psychiatric patients and 67% of the nonpsychiatric indicate they enjoy reading psychological literature. The only difference seems to be in whether they find the material helpful or not. The fact that the majority of those who read this popular psychological literature find it helpful seems to refute Wertham's opinion that they only *think* they are being helped. This would be an area for further investigation.

It is also of interest to note that a good number would like to see some of this material presented in more entertaining fashion such as TV, radio and movies. Inspection of the data indicates that this

The Efficacy of Reading

MORROW AND KINNEY

attitude was more prominent among those who claimed they did not enjoy this type of reading. The question we could not answer at this time is whether there is a high correlation between the 30% non-readers and those who claim they did not enjoy reading this literature. We would suspect that there is.

In analyzing the data we were impressed with the fact that the answers were, for the most part, superficial and that there was a need to go deeper, to determine the reasons behind the answers. If the person felt this literature was helpful, it should be important to know how or why; or if he expressed the feeling that it was harmful, we should find out in what way, etc. This could be determined by means of a focused individual interview rather than a questionnaire such as this.

It seems, in retrospect, that while the grouping of all this literature was helpful in obtaining a general or over-all viewpoint, some aspects require further elucidation. The fact that there was a difference in attitude toward the *Life* articles could mean that there might be felt individual differences toward other types of special books and articles, including some of the titles that made the best seller list. In other words, why were they so popular? Were readers impressed by the fact that this was a best seller and that some of the material should have been absorbed by them, or were the books and articles helpful, indeed, to the host of readers?

It would be of interest to study larger groups to see to what extent factors such as differences in age, education and length of stay in the hospital might influence or condition differences in attitudes. The fact that we have combined all the non-psychiatric patients into a single medical control group needs further thought and investigation. The intergroup differences

in attitudes on larger samples are worth studying to determine whether or not there are discreet subgroups.

As regards the psychiatric patients, it would be interesting to find out from them, as well as from their therapists, the extent to which such reading material is discussed in therapy. Another study which seems worth doing would be to determine how the hospitalized male population compares with nonhospitalized male controls and, if the two groups are similar, to consider broadening the utilization and application of these data for the population at large.

The findings suggest that a sizable number of patients was helped or at least influenced by the availability of the reading material in the library, as well as by the recommendations of librarians. It would be a fruitful source of investigation to compare attitudes and progress of patients in hospitals having libraries and librarians with those without libraries.

As was stated in the introduction, this study was undertaken in order to examine the attitudes of patients at this hospital toward the efficacy of reading popular psychiatric and psychological books and articles. The results have indicated that such reading material is considered valuable and that the library has an important place in its selection. The study itself has indicated a possible technique for further studies, as well as potential areas for future investigation.

REFERENCES

- American Library Association (Adult Education Board, Subcommittee on Book Appraisal). "Peace of Mind," *Library Journal*, 77(1952), 1439.
- Ryan, J. J., "Bibliotherapy and Psychiatry: Changing Concepts, 1937-1957," *Special Libraries*, 48(1957), 197.
- Sirovs, J., "Do You Practice Bibliotherapy?" *Hospital Administration*, 5(1957), 33.

U. S. Veterans Administration, *Special Service, Library Service, Medical and General Reference Library Division*. 18 p. Washington, U. S. Veterans Administration, 1952.

U. S. Veterans Administration Department of Medicine & Surgery. *Special Service, Library Service.*

Medical and General Reference Library Division. Bibliotherapy: A Bibliography. Supplemental List, 1955. 11 p. Washington, U. S. Veterans Administration, 1955.

Wertham, Frederic, "The Air-Conditioned Conscience," *Saturday Review of Literature*, 32(1949), 6.

A. E. ROSÉ, B.A.

C. E. BRAWN, M.A.

E. V. METCALFE, M.D.

Music therapy at Westminster Hospital

SURVEY OF THE LITERATURE

A survey of the literature readily available to us reveals a wide variety of therapeutic uses for music, some in which music is the core of the therapeutic method and some in which it is an adjunct to other therapies. Our survey also suggests some lack of clarity and objectivity in thinking, in theorizing and in reporting on activities in this field. In discussing the literature we shall limit ourselves to an attempt to pinpoint some of the highlights and deficiencies, and to classify the main uses of music as therapy.

Some writers deal with historical evidence of the healing power of music, ranging from the statements of Plato and Aristotle to the phenomenon of "tarantism" in Apulia, the use of music by primitive "medicine men" (9), and semi-magical

cures through music down to more recent times (21). These are of greater literary and historical than scientific value.

The value of music seems generally accepted as a relaxing and stimulating agent when used as background throughout any hospital. There appears, however, to be room for more objective evaluation of results where music is used thus extensively. Some of the clearer thinking in this field appears in articles describing the empirical use of music with many types of therapies as a distraction device, anxiety reliever and

Mr. Rosé is music therapist at Westminster Hospital in London, Ontario, and professor of music at the University of Western Ontario. Mr. Brawn is a psychologist at Westminster Hospital, where Dr. Metcalfe is chief of psychiatry service. Dr. Metcalfe is also senior associate in psychiatry at the University of Western Ontario.

relaxing agent. For example, it has been reported as of considerable value with surgery (22). It has also been reported as reducing the trauma and enhancing the relaxing effect of electro-coma therapy (16, 17).

As a direct agent, music has been used in treating both organic and psychiatric disorders. It has been of value for its rhythmic character in teaching co-ordination to retarded and cerebral-palsied children (12) and to brain-damaged patients (8). This may involve rhythmic physical activity aided by music, and in some instances the playing of rhythm instruments. Other active therapies using music are group singing, learning to play instruments, and the like with psychiatric cases (4, 6, 11). The value of such therapies seems empirically sound.

Various approaches have been taken with passive types of music therapy involving listening or exposure to music. Some authorities have attempted to relate the effect of specific types of music and even of specific selections to the diagnostic classifications of patients (18). Some have attempted to relate the effects of music to physiological change involving the autonomic nervous system or other metabolic processes (7, 10). Schoen says, "The sensorial response is physiological and possessed by all" (19). Others discuss the effect of music on emotions in more aesthetic terms which are difficult if not impossible to validate scientifically (2, 14). A few articles appear in which an attempt has been made to test and evaluate the effects of exposure to music empirically and objectively. For example, Mitchell and Zanker have carried out an experimental approach to music therapy (15). Blair and Brooking also report similar experiences and conclusions from their "music appreciation groups" (3). Their approaches involve rela-

tively small groups of patients listening to and discussing music with therapeutic results as a goal.

In summary, it appears that the following are the most important lines upon which music therapy is developing:

1. The use of rhythm to aid co-ordination, to stimulate activity and to encourage group participation.
2. The exploration of emotional responses to various types of music.
3. The use of music as a pleasurable experience in a group setting to stimulate discussion of moods and experiences.

We propose in the following pages to describe our own experience using this last approach with psychiatric patients.

BACKGROUND

In the fall of 1952 consideration was given to the inclusion of music in the broadening therapeutic program at Westminster Hospital. In the light of our understanding of music therapy under way elsewhere at that time, we felt that we could not proceed on predetermined lines, but only through a long and painstaking trial-and-error approach.

The proposed music therapist had had wide experience in various fields of music, performing in concerts and conducting opera, symphony and choirs, and was therefore accustomed to handling individuals as well as large groups of people. Would it not be possible for him, through a variety of musical media, to interest and maintain the attention of a group sufficiently to stimulate a discussion of the music and so lead into a group discussion involving the patients' emotions and problems?

In November 1952 a tentative program was established. At first one session a week was scheduled in a room with comfortable armchairs, tables and smoking facilities,

Music Therapy

ROSÉ, BRAWN AND METCALFE

having no resemblance to any of the treatment rooms. We had the use of a piano, a small portable record player and a blackboard. Each group consisted of eight or nine patients with one male and one female nursing attendant or nurse present. The session lasted from an hour to an hour and a half.

The program for the session included listening to and discussing records, and perhaps the life history of the composer or the performing artist, or any subject arising out of the discussion. Sometimes there was ensemble singing, in which we used books containing well-known art and folk songs. Eventually we saw that one period a week was insufficient. The lapse of time between sessions was found to be too long to assure continuity of procedure; memory often failed and we felt impelled to start our program from the beginning. To avoid this discontinuity and ensure a continuous series which would arouse and hold the interest of the patients from one meeting to another, we instituted in January 1955 two sessions a week for each of two groups.

AIM

From the beginning, music therapy in this setting was envisaged as a type of group therapy with music as a stimulating medium. We hoped that the music would arouse the wish in the patient to associate himself with the mood of the composition, thus bringing him to express his feelings and perhaps identify with the composer. In sharing the emotions stimulated by the music, he might often be relieved of tension, or by speaking about the feelings which the music had brought closer to the surface, might become aware of problems which bothered him at that time.

Van de Wall has expressed these same points as follows, "Through the process of

association then, music may increase our awareness of that part of the world which lives inside of us as well as of the external world, and also of the dynamic relation between the two. The process of association under the stimulus of music may build a bridge between ourselves and our environment, ourselves and the present, but it may also break off for the moment our relation with reality and the present and may isolate us in an imaginary world and time far removed from the place and people constituting our momentary physical and social environment" (20).

While the arousing of feeling and the facilitation of its expression are of first consideration, another important aim is to exert a socializing influence on patients. A function of the music is therefore to provide a purpose for the meetings in which changes in social consciousness may develop, ranging from toleration of others in a group situation to self-expression in a group and development of some social skills. Certain other benefits are expected to accrue—that is, the generally stimulating effect of the sessions as entertainment, some relief from the monotony of hospital life, the ego-enhancing effect of the attention received by patients in the group, and the possible development of a new interest. In addition, while the acquisition of knowledge of music is not an aim, it is expected that to some degree this will occur.

Music therapy is not expected to cure; it is one of the many aids we are trying to find to make general treatment more effective. We feel that we should always keep in mind that these sessions are not intended to instruct patients in music in order that they may "pass an examination" or make a professional choir or ensemble. Music is a universal language which does not have to be translated or re-formed to be understood. It affects the emotional

part of the human being without making it necessary for him to use his intellect. Music should be a means by which we try to reach the emotions of the patient, so that he may be conditioned to a more receptive basis for psychiatric and medical treatment.

REFERRALS AND COMPOSITION OF GROUPS

Patients are referred for music therapy by the psychiatrist. Sometimes referrals are on the suggestion of the psychologist or on the patient's own request. While the crit-

eria for referrals are rather flexible, in general they are the patient's capacity to benefit from the experience and to contribute to the group's activities.

Each group consists of from 6 to 12 patients, one male and one female attendant, the music therapist and a psychologist. The psychiatrists also join the group when they wish. Patients are predominantly male since the proportion of female patients in the hospital is small. No selection according to diagnosis is exercised though there is a preponderance of schizophrenics because of their numerical superiority in

Music Therapy

Referral form

Psychiatric Institute

NAME OF PATIENT AGE DATE

DIAGNOSIS WARD PRESENT TREATMENT

PRESENT ATTITUDE AND BEHAVIOUR OF PATIENT:

<i>General:</i>	Hyperactive?	Retarded?	Depressed?	Hallucinations?
<i>Social attitude:</i>		Withdrawn?	Negativistic?	Apprehensive?
(check or circle		Hostile?	Irritable?	Suspicious?
relevant words)		Sociable?	Cooperative?	Cheerful?
		Passive?	Aggressive?	Tense?
		Manneristic?		
<i>Conversation:</i>		Spontaneous?	Relevant?	Intelligent?
		Appropriate?	Hard to elicit?	Reticent?

PATIENT'S INTEREST IN MUSIC:

Did patient ask to come:	Yes?	No?
Did he express positive interest when approached:	Yes?	No?
Has he specific interests in music?	Please specify	
Has he special training in music?	Please specify:	

SUGGESTIONS FOR HANDLING:

FAMILY BACKGROUND, EDUCATION, SOCIAL STANDING:

CAUSES OF ILLNESS:

the hospital. Some patients are from closed wards and some from open wards. Disturbed patients are not excluded unless they are disrupting to the group. In making new referrals, other aspects being equal, priority is usually given to recent admissions, patients on an active treatment program, and patients with relatively favourable prognosis. At present there are two groups, each meeting twice weekly. While it is intended to keep the groups fairly equivalent, their degree and type of responsiveness varies according to the personalities of the patients in each, and new referrals are often allotted to the group in which it is felt they will fit best or can make their best contribution. As far as is feasible, the groups are kept equal in number. Our referral form, on page 96, is self-explanatory.

SELECTION OF THE PROGRAMS

We feel that "classical" music (including modern compositions) offers the best possibilities of arousing feeling and stimulating discussion. A wide variety of symphonies, concertos and other ensemble music has been used, as well as vocal works, although some lighter selections such as folk songs and songs from musical comedy have been played. On rare occasions modern jazz and popular singers have been heard at the specific request of some patients.

The therapist himself chooses the music to be presented, although suggestions from the group are always welcomed. In the selection of music he has been guided by a number of observations gathered in a lengthy period of experimenting. While the response to the music played is still unpredictable, certain guides have proved effective:

- It is important that variety be applied to the choice of programs. The therapist

draws from his own large record collection as well as from a growing record library in the hospital.

- In the therapist's opinion, patients are most affected by changes in the tempo of the music. Other factors governing the therapist's choice, in order of importance, are rhythm, melody and harmony.

- The therapist believes that orchestral music is more likely to arouse interest than other types. Music of varied emotional colour will provide a range of opportunity for the patient to express feelings.

Mitchell and Zanker (15) have tried to establish the characteristic reactions of their groups to various *styles* of music: classical style, including Bach, Handel, Haydn, Mozart, Beethoven; romantic style, comprising Schubert to Brahms and Wagner and the nationalist composers such as Grieg, Dvorak, Mussorgsky; modern impressionist style, as for instance Debussy, Saint-Saens, Butterworth; and contemporary music, such as Sibelius, Stravinsky, Bartok, Hindemith.

Capurso (5), on the other hand, has exposed a group of normal subjects to music selections, and has asked them to choose one of the following six categories, which would described the effects of the composition:

- A Happy, gay, joyous, stimulating, triumphant
- B Agitated, restless, irritating
- C Nostalgic, sentimental, soothing, meditative, relaxing
- D Prayerful, reverent
- E Sad, melancholy, grieving, depressing, lonely
- F Eerie, weird, grotesque

Both these above approaches, then, ostensibly provide a guide for the selection of music which will have given desired effects on the patient-listeners. However,

in our own work, although we have noted apparent effects of certain selections on patients, we have found that these effects are not consistent or predictable. We therefore agree with Blair and Brooking, who state in this regard, "It is our contention . . . that the mental attributes associated with the appreciation of music are so complex, the variation of response so vast from one individual to another and from one time to another within the same individual, the variety of musical compositions so enormous, and the circumstances of each person so changeable from day to day, that no scientific statistics are ever likely to be produced for music therapy" (3, p. 234).

From time to time, as special needs or opportunities arise, we try additional activities and procedures. Occasionally films of musical interest are shown to the groups, enabling them to visualize what they hear. (There are about 20 films available to us from the National Film Board, ranging in duration from 9 to 42 minutes.) Subjects are vocal performances, orchestral programs, ballet and folk songs. In scope they range from classical music to jazz and include solo work and small combinations.

Another activity the patients experience is a series of concerts held at the University of Western Ontario on Sunday evenings. These performances offer a variety of singers, instrumentalists and choirs. Therapist, psychologist, patient, attendant and volunteer-driver enjoy these concerts as social equals in all respects. These concerts also give interesting discussion matter in subsequent music therapy sessions.

It is gratifying to notice the increased attention and appreciation on the part of the patients when live music is also brought into the groups themselves. As Licht states, "There is . . . a sense of satisfaction in the corroboration of the auditory and visual images. When the sound is musical the

desire to see its production is greatly increased" (13). These live programs appear to have played a part in arousing the wish in some patients to perform on an instrument themselves. Some have had previous training and others have no instrumental background whatsoever. One patient, who had some knowledge of the piano, prepared and presented a short program for the group, which was warmly applauded. This brought about a feeling of self-assurance and achievement in the performing patient. Another patient (leucotomized in 1951) after a year of piano instruction begun in 1955 has recently shown increasing sensitivity to phrasing and dynamics without specific instructions from the therapist.

Another case of individual sessions has been successful. This patient had a high-pitched voice, of which he was very conscious. For some months the therapist held regular voice sessions with him. After approximately four months he was able to use a normal range without effort and could sing some easier songs in baritone. The knowledge that he could speak and sing in a normal and inconspicuous range greatly helped his self-confidence and general attitude.

It remains to be seen if, in case of specially talented or interested patients, individual therapy sessions will speed up any improvement and complement the team work, or make patients less adaptable to group meetings.

PROCEDURE

As noted earlier, the groups meet in a comfortable, informal setting. At present a record player of good reproductive quality with automatic record changer is used, an improvement over the portable player originally provided. Records are selected and the machine is controlled by the music therapist. Each other member of the group

Music Therapy

ROSÉ, BRAWN AND METCALFE

selects his location from the chairs arranged in a circle which includes the therapist and the record player. Attendants sit in the group or remain at the back of the room as they wish.

When the group is assembled and initial casual conversation has died down a record is started by the therapist, usually without preamble, or at least without giving the title or composer or any information as to the nature of the music. Whenever natural breaks occur in the music—for example, the end of a movement—they are used as stopping places for discussions, several such usually occurring in the course of a session. Each break lasts as long as patients are interested in discussion; then the recording is continued or another selection played. The therapist and the psychologist join in the discussion and attendants have at times taken part.

In fostering the atmosphere of equality which was desired and in realizing our aims of socialization and expression of feeling, certain devices and techniques have developed. Patients often require some time after the music ceases to compose themselves to speak, and the temptation for the psychologist or therapist to break the silence is resisted unless no patient speaks for at least a full minute. The value of such periods of silence, however, are dependent upon a relaxed appearance and attitude on the part of the psychologist and the therapist since any tension on their part is quickly conveyed to the group. Nor should there be any pressure to speak felt by patients in the form of expectant looks. These will make some uncomfortable, causing a desire to withdraw, while others will comply by making a type of remark which expresses no real feeling. Each remark made by a patient is acknowledged if addressed to the psychologist or therapist, or if no other member of the group follows it up, by at

least a nod of acceptance. He thus achieves some satisfaction and feels encouraged to express his thoughts and feelings again. Direct questions are avoided as far as possible in order to avoid demand on withdrawn patients which will make them feel uncomfortable. A question may, however, occasionally be directed to a patient who seems to wish to speak but cannot find the courage or the opportunity.

If no response from patients is forthcoming the therapist or psychologist may make a statement expressing some aspect of the feeling conveyed to him by the music. This will often be sufficient to start some discussion and is felt to be preferable to questioning or otherwise indicating expectation from patients. If no spontaneous response can be obtained it is deemed wiser to continue with the music rather than create or prolong any tension or arouse feelings of discomfort in patients.

It has been considered important for our purposes that patients' verbal responses are spontaneous and reflect their own feeling or thinking. Care is taken, therefore, not to precondition them before playing the music, particularly as to what kind of feeling it is expected to arouse. Some will look for clues to ensure a "correct" comment. Equal acceptance is given to positive and negative expressions and in general an effort is made to avoid giving any impression of correct or incorrect responses or of any one feeling in regard to a selection as being the only appropriate one. Every effort is made to encourage independent feeling and expression on the patients' part. The roles of the therapist and the psychologist are kept to a minimum and are felt to be chiefly useful as a catalytic influence.

ROLES AND RELATIONSHIPS

Because of his wide range of experience in and knowledge of music, it becomes the duty

of the music therapist to select appropriate music and programs for these sessions. He may be influenced in his selection by suggestions from the psychologist, the psychiatrist and the patients. He tries to select the numbers according to his musical and therapeutical experience. The attending psychologist, or psychiatrist, discusses with the therapist the varied effects on the patients. The music therapist has the active co-operation of psychiatrists and psychologists on the hospital staff. He is a part-time member of the staff and cannot follow the daily changing details in the patients' lives. Therefore, we feel the presence of a psychologist who is familiar with the background, problems and behaviour of the patients is important. He may be able to observe the patients while the therapist is busy with mechanical matters of conducting the session. He may be able to understand and possibly interpret silent and vocal reactions to music and ensuing discussion. At first we felt that the psychologist should be a silent observer, but we have learned that he can be used to much greater advantage by being a participant-observer.

An atmosphere of permissiveness and equality is thought to be most likely to foster our chief aims of expression of feelings and socialization. The roles of the music therapist and the psychologist are therefore conceived as those of members rather than leaders in the group. They strive to be as non-authoritarian as possible, and no discipline is exerted in the group unless absolutely necessary. Only incidental value is placed on acquiring knowledge, but any verbal expression on the part of any patient is accepted. In other words, it is hoped to develop a normal pleasant social group devoid of hospital or classroom atmosphere in which each person can feel free to express his feelings and opinions as an equal.

After each session there is a discussion between the music therapist and the psychologist. The relation of the music to the emotions produced and the type and amount of group interaction is discussed. Reaction, or lack of it, on the part of specific patients is considered. If special problems arise, the psychiatrist is consulted for further comments or suggestions. The psychiatrist ordinarily plays no direct part in the sessions. He may attend and participate if he wishes. However, he is kept informed of his patients' progress, or lack of it. His most important role is acting as consultant and adviser.

We have found it quite important that all members of the staff, particularly nurses and nursing attendants, understand the nature and significance of music therapy. With this knowledge they will co-operate much better in encouraging patients to attend music therapy and to talk about it afterwards, while without it they may regard music therapy as another fad.

GROUP DYNAMICS

There is considerable variety in the type and amount of participation among patients. A few withdrawn schizophrenics have been unable to tolerate the group situation and have been allowed to leave after one or two sessions. Some others, while they never speak in the group, continue to be present willingly and some of these appear to enjoy the sessions. A number who initially were silent have achieved the courage to speak spontaneously occasionally, after a long period of attendance. Other patients begin expressing themselves spontaneously as soon as they join the group. Many are intellectually and emotionally intact enough to enjoy the sessions and express their feelings appropriately from the beginning. Some, however, may hamper

Music Therapy

ROSÉ, BRAWN AND METCALFE

the group by their intellectualization, by dominating the group by their superior knowledge, or by attempting to monopolize the attention of the therapist and psychologist, thereby discouraging others from speaking and preventing any real group feeling.

One might divide all responses which occur into two classes, those which are expressions of feelings and those which are intellectual devices. The former may take the form of statements involving merely liking or disliking the music. Some may name or describe the feeling conveyed by the music. Responses also may describe visual imagery stimulated by the music such as different kinds of landscape, different times of day, and moods of nature. Feeling is usually inherent in these. The second type of response is often a remark or question about the technical aspects of the music—for example, the form of the composition, the name of the composer, the key in which it is written, or the instruments used. Another such device is a personal experience such as having heard something like it, or attended a concert which it recalls, or sometimes a monologue which is not too relevant but which has its beginning in the music played. The motivation behind this kind of response varies. Some are obviously "red herrings" designed to lead the group away from discussion involving feeling. Others are ego-enhancing devices used by more voluble patients who obtain satisfaction from holding the attention of the group or displaying superior knowledge. Some patients can participate only in such intellectualized ways since they maintain themselves habitually by rigid intellectual defences. A few such responses represent a real seeking of information.

In subtle ways the type of response involving feeling is encouraged and the intellectualized type, while never rejected, is not given as much attention. Questions

asking information are always answered, regardless of the motivation. The therapist or psychologist, however, may frame the answer or response in a way which invites some elaboration from the patient on a feeling level or may end with a question involving feeling. It is important to know the patients and to sense the motivation to know how to respond to such remarks and questions. The direction discussions may take is not always predictable. Patients will not as a rule air very personal material in the group, nor is this felt to be desirable. Individual problems on a more superficial level are expressed at times, and problems of human beings in general sometimes are discussed. Religious, political and international affairs have been brought up, and opinions expressed about prominent figures on the national or world scene. This is not discouraged but tolerance and broadmindedness are always given encouragement. Speculation as to the mood or feelings and the personality of the composer sometimes forms part of the discussion. In fact, if no spontaneous discussion arises, the giving of a little information of this sort is sometimes used in an attempt to arouse interest and invite questions or comments. In conversing along these lines patients usually attempt to identify with the composer even though they are unaware that their own feelings are involved in this activity. At times, however, it may lead to more personal observations.

OBSERVATIONS

When using records, it has been our experience that the general tone-level—that is, the "loudness"—should be slightly raised most of the time if the group consists mainly of schizophrenic patients, because it takes a greater tone intensity to penetrate the wall of perception and to hold their interest

for any amount of time. At the start in 1952 we operated with a small portable record player of minimum tone clarity. There was much distortion, and volume and colour were lacking. This may have actually alienated some patients rather than have interested them in the medium of music. With the use of a high fidelity player we now can produce more intense responses in patients and enhance their enjoyment in listening. The difference in tone and colour was immediately recognized and commented on by patients.

As with normal listeners, patients will have varying responses to different instruments. In the therapist's opinion, violin or flute may generally have a soothing effect on excited listeners, but may usually not bring a modification of mood in depressed patients. He feels that an ensemble of instruments of more varied tone colour—for instance, piano, violin and cello—has a more decided effect on the patient. Altschuler agrees with this last observation (1). It seems that the variety of instrumental colour is an important factor in keeping the patient's attention for any length of time. Thus modern symphonic music—Stravinsky, Shostakovich, Prokofiev—is more likely to bring about reactions, positive or negative, while records of solo instruments may hold the patient's attention only for a short while. Generally, the more varied and the larger the instrumental group, the more noticeable the impact on the listener. Occasional repetition of selections will usually bring forth new details, which will eventually cling to the mind of the patient, increasing his enjoyment in the particular piece. Familiarity may arouse sentiment and give satisfaction.

We have found a music performance of approximately 40 minutes actual playing time the optimum length. When discussion is vigorous this is more than ample;

when the general mood of the group is less responsive, we extend the time of performance.

Our experience suggests that the most effective participation is obtained with groups of from 6 to 12 patients. The therapist can devote special attention to the individual patient and take suggestions from him as to the kind of music to be used. This gives the patient more of a feeling of active involvement in the program. Listening to music together or singing together will bring forth a feeling of importance and perhaps well-being in a patient, who feels that something is being offered him beyond the usual medical care. As listening is active participation in a common enterprise (often as active as singing or playing), it frequently takes the patient out of his mental seclusion and arouses emotion.

DISCUSSION

Music therapy as herein portrayed has developed as an empirical therapeutic effort rather than as a planned research project. Since no control groups have been set up and no objective means of evaluation devised, one cannot definitely attribute changes in patients to music therapy exclusive of other aspects of the total therapeutic program in the hospital. We may, however, attempt objectivity in our observation of the group in action and in stating our opinion as to its effects.

While the principle of non-authoritarianism on the part of the therapist and the psychologist has been inherent from the beginning, the mechanics of this role have evolved through a gradual learning process. We feel that we have succeeded to the extent that patients often take the lead in discussion and carry it on among themselves, that a considerable proportion of them join in discussion, and at times may

Music Therapy

ROSÉ, BRAWN AND METCALFE

not agree with an impression expressed by the therapist or the psychologist. They also express negative feelings towards some selections. Complete success in this role-playing has not been achieved, however, since patients at times look to the therapist and the psychologist to initiate and mediate discussion, and tend to address their remarks to them rather than to the group as a whole.

We feel too that some progress in developing social attitudes has been achieved. Some withdrawn patients have initially been scarcely able to tolerate the group situation, but have gradually become comfortable and interested, and some of these have learned to contribute to discussion and express feelings about the music. A few, however, have not progressed beyond mere toleration of the group situation. Some group feeling and friendliness among patients is noticeable, and at times discussion involves a real exchange of ideas and empathy with others. Disagreement also occurs without rancor.

Some voluble, aggressive and even hostile patients, have learned to limit themselves to an appropriate share in discussion, to present their views more reasonably, and to attempt to attune their behaviour to the group atmosphere to a greater extent. This has not always been the case, however. One hostile and domineering female patient, for example, dominated the group as long as she remained in it, and an increase in other patients' contributions and a more relaxed atmosphere soon developed after her discharge from hospital. Another patient was eager to join the group and proceeded to attempt to use it for his own ego-enhancement, but soon withdrew of his own volition when the group failed to receive his opinions with the enthusiasm he expected.

While a very personal level of expression of feeling or discussion of problems seldom

occurs, we feel that this actually gives music therapy a unique and necessary place in the therapeutic program. The medium of music makes it possible for emotion to be recognized and put into words in a less personal and therefore less threatening way. Human problems on a general level are often brought out as a result. Music stimulates feelings and is enjoyable and thus camouflages the therapeutic purpose from patients while it gives pleasure and aids relaxation. For this reason we feel that music therapy benefits some patients who are not yet able to tolerate a more direct approach to their problems, and may prepare the way for other forms of psychotherapy on both an individual and group basis. Mitchell and Zanker feel that music allows the most indirect form of emotional release, and they state in discussing their observations, "Our earlier assumptions that the subverbal response to music possesses advantages in all patients (but especially the most inhibited) over more direct forms of self-expression through art, appear to be justified. This suggests that for some patients a preliminary approach through music might facilitate other therapeutic methods of reaching the unconscious" (15).

The incidental benefits of imparting knowledge of music, of stimulating interest in it and of providing an enjoyable break in the weekly routine have been achieved also to a considerable extent with a majority of patients. Many have broadened their appreciation of music to include classical forms formerly unfamiliar and in some cases distasteful to them. Mitchell and Zanker also report, "As the sessions proceeded education resulted in increased appreciation of the classics whereas other types of music were more immediately appreciated" (15). We feel that this interest may continue in many cases and provide a source of satisfaction and an emotional out-

let which may aid adjustment outside hospital.

To some degree patients, in discussion, are complying with what they feel is expected of them, and are tailoring their expression to the atmosphere which has been largely created by the therapist and the psychologist. We feel, however, that this is a normal and useful social skill which, while not striven for in this situation, does not detract from the therapeutic value of the sessions.

With time given, a great deal will be learned in the field of music therapy. Although we cannot claim unqualified success, we feel that our approach has had beneficial effects. Further experience, with critical and objective observation, may give more insight into the dynamics of the situation, thus making our aims and principles clearer and increasing our skill in the mechanics of this form of therapy.

BIBLIOGRAPHY

1. Altshuler, I. M., "The Past, Present and Future of Musical Therapy," in *Music Therapy*, edited by E. Podolsky. New York, Philosophical Library, 1954.
2. Bennet, V., "Music and Emotion," *Musical Quarterly*, 28(1942), 406.
3. Blair, D. and M. Brooking, "Music as a Therapeutic Agent," *Mental Hygiene*, 41(1957), 228.
4. Browne, H. E., "The Use of Music as a Therapy," *Mental Hygiene*, 36(1952), 90.
5. Capurso, A., *Music and Your Emotions*. New York, Liveright, 1952.
6. Donais, D., "Music Sets the Stage for Recovery from Mental Diseases," *Modern Hospital*, 61(1943), 68.
7. Ellis, D. S. and G. Brighouse, "Effects of Music on Respiration and Heart Rate," in *Music Therapy*, edited by E. Podolsky. New York, Philosophical Library, 1954.
8. Fields, B., "Music as an Adjunct in the Treatment of Brain-Damaged Patients," *American Journal of Physical Medicine*, 33(1954), 273.
9. Friedman, M. H., "Therapeutic Uses of Music," *Medical Annals of the District of Columbia*, 22(1953), 421.
10. Grunewald, M., "A Physiological Aspect of Experiencing Music," in *Music Therapy*, edited by E. Podolsky. New York, Philosophical Library, 1954.
11. Harrington, A. H., "Music as a Therapeutic Aid in a Hospital for Mental Diseases," *Mental Hygiene*, 23(1939), 601.
12. Jeffrey, W. E., "New Technique for Motivating and Reinforcing Children," *Science*, 121(1955), 371.
13. Licht, S. D., *Music in Medicine*. Boston, New England Conservatory of Music, 1946.
14. Masserman, Jules H., "Music and the Child in Society," *American Journal of Psychotherapy*, 8(1954), 63.
15. Mitchell, S. D. and A. Zanker. "The Use of Music in Group Therapy," *Journal of Mental Science* (London), 94(1948), 737.
16. Murdock, H. M. and M. T. Eaton, Jr., "Music as an Adjunct to Electro-shock Therapy," *Journal of Nervous and Mental Diseases*, 116(1952), 336.
17. Pace, Henrietta G., Virginia Mountney and Ruth Knouss, "Selection of Music to Accompany Electro-shock Therapy," *Occupational Therapy and Rehabilitation*, 29(1950), 220.
18. Podolsky, E., "Music and Mental Health," in *Music Therapy*, edited by E. Podolsky. New York, Philosophical Library, 1954.
19. Schoen, M., *The Effects of Music*. London, Kegan Paul, 1927.
20. Van de Wall, W., *Music in Hospitals*. New York, Russell Sage Foundation, 1946.
21. Vaultier, R., "La Musique et la Medecine," *Presse Medicale* (Paris), 62(1954), 1187.
22. Willard, J., H. M. Livingstone and R. E. Brown, "How Music in the Operating Room Robs Surgery of Its Terror," *Hospital Management*, 74(1952), 40.

PAUL HOOVER BOWMAN

The role of the consultant as a motivator of action

The term consultant is becoming increasingly popular. There are legal consultants, business and industrial consultants, medical and insurance consultants. School systems are converting supervisors into consultants. Some cities and states are hiring mental health consultants.

Is this new emphasis on consultants a change of name only or of function? Undoubtedly, in some situations no change of function is involved, but presumably there is something about the true "consultant" that distinguishes him from others of his profession that are not in the consultant role.

What is a consultant and what does he do? Most simply, he is a specialist in some field of endeavor who helps others solve their business or professional problems. His task is to bring expert knowledge to the

solution of some definite problem. He works for other people, through other people and, if successful, works himself out of a job.

This definition of the role, however, involves two quite specific but different functions. The first is the *knowledge* function, that of analyzing the problem and bringing to it the necessary information and ideas to help solve it. The second is the *motivation* function, that of helping people to define their problems and then to mobilize their own resources for actually carrying out any action program or change. It is usual to think of the consultant mainly in terms of

Mr. Bowman is research associate at the University of Chicago and chief consultant to Quincy's community youth development project, referred to in this paper.

the knowledge function; actually, the major problems for the consultant seem to be in the area of motivation. If problems could be solved simply by making available the necessary information and knowledge, the consultant's task would be greatly simplified. Perrin Stryker, writing in *Fortune* magazine about the consultant function in industry, says, "Outside consultants simply do not solve the problem. They may be fully qualified and can give endless advice, but they can't tell us how to put *their* knowledge to *our* practical use." He adds that the best test of a consultant is his ability to get company personnel to cooperate in adopting new techniques fitted to their needs—a motivational problem.

Our staff is currently engaged in a 10-year community action research project in which the role of the consultant is of central importance.¹ The purpose is to determine whether social scientists can be effective in improving the mental health and talent development of children when they act as consultants to an entire community over a period of ten years. It is not too difficult to identify problems and outline the needed skills and services, but how can a community be motivated to *want* to improve its services to children? What method can or should be used in trying to promote change? This question is further complicated by the fact that this project was initiated by a university rather than by the community itself. It is obvious that its success hinges on finding answers to the motivation function of the consultant.

This paper will examine the methods of motivation we have used as consultants

and the successes and failures we have experienced.

METHODS BASED ON EXTERNAL FACTORS

Consider what frequently happens in the work of a consultant. Perhaps a city government calls in a traffic consultant to help on parking and flow-of-traffic questions. The consultant collects the facts about the city and its traffic, analyzes his data, and on the basis of his knowledge and experience submits a report with his recommendations to the city council. Here his responsibility ends; the knowledge function has been fulfilled to everyone's satisfaction. However, all too frequently the report goes against some local tradition, costs too much or is opposed by powerful interests within the community, and it is filed away with little, if any, action. What approaches can be used if the consultant or others are interested in promoting actual community change?

Methods of authority. The speediest way to effect some kinds of change is to command them, but this presumes the existence of the authority to command. By the very nature of his position the consultant usually does not have that authority, and so he must necessarily obtain the support of at least a few influential persons who do have such authority. However, the consultant is not completely empty-handed in this regard, for the informal authority of his own professional status is often highly regarded.

Even though our project staff has no direct authority in the community, informal authority has had its place. The prestige of the university and the professional status of members of the faculty who originally met with community leaders to plan the project were instrumental in getting the project accepted. A university representative spent three months explaining the project to business and professional people,

¹ For a detailed progress report on this project see Paul H. Bowman and others, *Mobilizing Community Resources for Youth*, Supplementary Education Monographs No. 85, University of Chicago Press, October 1956.

The Role of the Consultant

BOWMAN

individually and in small groups. The project founders stipulated that a group of citizens representing the boards of the youth-serving agencies should make the decision whether the project should be started in this community or not. Such a group met and constituted themselves the Youth Development Commission, thus providing the base of authority for the project.

This method of authority therefore came into play mostly in the beginning of the project and mostly in dealing with business and professional leaders of the community. Professional prestige proved to be of little use in dealing with citizen groups; in fact, it was at times a barrier that had to be overcome in certain working relationships. The relative youth of some staff members was something of a disadvantage at the beginning, as age and experience are in themselves symbols of prestige.

Method of emotional contagion. This is another method commonly used to motivate action. It is used in many mass efforts, such as fund-raising campaigns and advertising, and also in personal contacts between individuals.

In our project we have thus far made little use of mass approaches to the community, even though this may become necessary in later stages of the project. We joined with other agencies in sponsoring "My Name Is Legion," a mental health play on the life of Clifford Beers, that carried an emotional impact to four hundred listeners. Perhaps the speeches given to P.T.A.'s and service clubs might be regarded as mass motivation, but if so it is mild indeed. We sponsored two dinners during the first years for the volunteer workers on teams, where talks were given on the importance of their work.

It is impossible to estimate the effectiveness of the emotional contagion of personal contacts between people associated with the

project and the community at large. The staff, commission members and volunteers have had many contacts with a variety of people, and confidence, or lack of it, engendered through such personal contacts is important.

Method of reward and punishment. This method of motivation when used with adults might be compared to a barter system: "I offer you something you want if you will do something I want." This is the basis of many contests and incentive systems as well as of many social and business obligations.

We know of no use of punishments in this project, but rewards in different forms have been tried at times as motivating stimuli. We have offered the reward of academic credit in connection with several of our training courses for volunteers and teachers. This proved to be particularly effective in getting teachers to enter the training course, since they received salary raises for additional training; however, a limited number of these dropped out as volunteers when the course was over, and we have felt that these were likely the ones who were most attracted by the reward of credit. We have also helped the school system obtain several grants of money to undertake experimental programs in testing and in the schooling of talented children. Progress in these areas has, however, been very slow.

A slightly different form of reward is recognition given for work already accomplished. We have attempted to give professional recognition to some by inviting them to the university campus to speak, to others by inviting them to co-author articles and monographs, and to still others by offering scholarships for summer work. This type of reward has proved somewhat more appropriate to the goals we are trying to achieve.

METHODS BASED ON INTERNAL FACTORS

Method of tapping existing motivation. The three methods discussed above have several common elements. The goal is rather specific and often predetermined by the consultant. The methods of reaching the goal are outlined in advance by him, in terms of his analysis of community needs. The emphasis is on the arousal of a given motivation.

The fourth method is somewhat in contrast to these and relies on the discovery and utilization of existing motivations rather than on the arousal of new ones. It is aimed at aiding individuals and agencies to assess and clarify their own needs, helping provide avenues for satisfaction of needs, and introducing new types of experience through which existing interests and motivations might be broadened. Here the goal of the consultant may still be predetermined, at least in the general sense of helping to solve a problem, but he has less assurance that his goal will be chosen or achieved. The methods are not outlined in advance but rather developed step by step. Few of the basic decisions are made by the consultant, and he is more concerned with the people and their interaction than with a particular solution.

At the beginning of the third project year the staff felt the need to find more effective methods of motivating action. The outcome of study by the staff was the decision that we should put to full use for one year this method we now refer to as tapping existing motivation. Since then we have tried a variety of ways to discover and put to work the motivations that already exist within the community.

One of these, and the first one in point of time, was merely *helping people to clarify* in their own minds what their needs were.

For instance, we went to the heads of the youth-serving agencies and schools and asked, "What is it you need to be able to do here the kind of job you would like to do?" This resulted in thoughtful and stimulating interviews. Several of these persons later verbalized that this was the first time anyone had come to them without asking for something and that they were surprised and interested. For us it meant that we found some mutual concerns with a number of people and some areas in which we could be of help to them. We also held personal interviews with all of our own volunteers to determine their major interests and needs, and then tried to reorganize the volunteer tasks around these needs. In retrospect we see this as a crucial step in finding a more effective consultant role.

As another way of discovering existing motivations, we used *opinion surveys* to highlight to the community some common needs. For instance, a survey of the meager offerings in adult education and a discussion of these findings in a committee meeting of agency heads stimulated several new efforts. A survey of the recreational needs of youth served to focus attention on the question of youth centers and "hot-rod" clubs, and some definite action resulted. A survey of the number of poor readers brought to light the need for remedial reading in the schools, and one remedial class was formed. A survey of the needs of principals and teachers highlighted the problem of the maladjusted pupil, and a successful workshop was held on this problem.

In addition to trying to clarify and highlight existing needs, we have attempted through *demonstration activities* to acquaint people with various possibilities for action. We ourselves have led parent discussion groups and have held leadership training courses for various agencies; in these we have used movies, recordings and role-play-

The Role of the Consultant

BOWMAN

ing to demonstrate different approaches to children. A counseling seminar with ministers, two training groups in play therapy, and a number of cases handled successfully for doctors, schools, courts and parents demonstrated the value of therapeutic work. While many of these activities did not directly benefit the experimental group with which we were concerned, we hoped that they might serve to broaden the interest, understanding and concern of the community for its children.

There is some evidence that the demonstration work done in counseling is responsible, at least in part, for the establishment of a mental health clinic. It is likely that some group therapy will be used in the schools in the future, owing to a demonstration of its effectiveness. Recreational clubs set up as a demonstration in two low-income areas have motivated the Scouts to look more closely at the ability of their program to interest these boys. The monthly meetings of a professional advisory committee have demonstrated to agency heads the value of informal, regular contacts among them, and this has since been incorporated into the Welfare Council. The demonstration of "painting picnics"² was sufficient to interest an agency in making it a permanent part of its program.

When we discovered a desire to provide services for maladjusted or gifted children, we tried to tap and broaden it by supplying some *new experiences* to the people involved. Two teachers interested in gifted children were sent to a summer workshop on the West Coast, and teachers and administrators have visited other school systems at different times. The executive committee of the Welfare Council visited a city nearby to see other methods of operation. The mental health group visited other cities to observe clinics in operation. A newly elected county judge spent a week observing

the work of other communities in the state. We have hoped that such new experiences might increase the motivation that people have for doing something in their own community in their area of interest.

DISCUSSION AND EVALUATION

Thus far in this paper I have been describing our consultant activities in terms of the kind of methods used. I should, however, submit our subjective evaluation of their effectiveness, even though we are still in the middle of the project.

To date we feel that the consultant's use of *authority* is most necessary and successful in gaining acceptance of a project from the power structure of the community. It is less effective when used with other groups of people and for other purposes. When successfully used, it can produce rather quick results but does not help create initiative and motivation in others. Stressing the professional status of the consultant or his institution and calling on the support of influential people in the community are two means of utilizing authority.

Emotional contagion seems to be most effective as the natural expression of the interest of individuals in their personal contacts with others. Mass attempts to motivate others for youth work require much effort and are of questionable value.

When the consultant uses *rewards*, he should recognize that there is a danger that the rewards will become more important than the goals. It is likely also that those people attracted by rewards will drop their support when the rewards are no longer

² This was a weekly activity initiated by the staff during summers to stimulate artistic development among young children. Children and adult artists visited local points of interest and painted pictures "for fun," played games, ate lunch and talked—doing together rather than having class.

offered. Thus, rewards are more useful in motivating hard work for a short period than in producing creative and long-term effort. Rewards in the form of sincere recognition for service already rendered seem more effective than as ends to be pursued.

The greatest single resource for community youth work is the interest, love and concern for children already existing in many citizens. The most effective method by which a consultant can help motivate the community, we feel, is by tapping existing motivations—that is, by locating those people who are interested in children and by planning ways to utilize their ca-

pacities. This method moves more slowly and with some confusion, but it is more likely to result in others assuming responsibility and discharging it conscientiously and with imagination. When this method is used, there is often a natural reward to those involved, because they are doing something they enjoy and at the same time something that others need.

Our type of consultant role in helping mobilize a community to action in behalf of its youth may be unique, but the experiences we have had seem to us to hold implications for many types of consultant work. We hope that it can be more adequately studied here and elsewhere.

ALLEN HODGES, Ph.D.

DALE C. CAMERON, M.D.

Minnesota's community mental health services

Contributions of local mental health facilities are now recognized as an important facet of a preventive psychiatric program. The process of establishing local community mental health programs in rural areas presents unique problems, particularly in sparsely populated areas. Geographically, Minnesota's population is almost equally divided between urban and rural. According to the 1950 census, 55.7% of 3,148,000 Minnesotans reside in rural areas.

As to available out-patient psychiatric services, less than 8% of these services are located in rural areas although over half of the population resides in rural localities.¹ This was the challenge to an integrated statewide mental health program in 1955.

HISTORY OF MINNESOTA'S OUT-PATIENT PROGRAM

Records reveal that as early as 1920 a child guidance clinic was proposed for the Minneapolis-St. Paul metropolitan area. In 1923-24 through the initiative of Dr. Arthur Hamilton, then chief of psychiatry at the University of Minnesota, a demonstration child guidance clinic was established under

Dr. Hodges is psychological consultant on community mental health services and Dr. Cameron is medical director of the Minnesota Department of Public Welfare.

¹ A. K. Bahn and V. D. Norman, "Out-Patient Psychiatric Clinics in the United States", Washington, National Institute of Mental Health, 1956. (Mimeographed)

sponsorship of the Commonwealth Fund and the National Committee for Mental Hygiene. The impetus of this demonstration clinic cannot be minimized, for as a direct consequence three additional out-patient child guidance clinics evolved. In 1924 the Wilder Child Guidance Clinic was established in St. Paul under sponsorship of the Wilder Foundation. In 1924 the Minneapolis Public Schools sponsored a child guidance clinic open to all children of the Minneapolis area. In 1924 a traveling child guidance clinic sponsored by the University of Minnesota operated in Duluth and Mankato; this traveling clinic, while short-lived (1924-25), laid the groundwork for future developments.

In 1938 Duluth established a permanent out-patient clinic under the sponsorship of the Junior League. The city of Rochester and Olmsted County financed an out-patient facility in 1948. Additional child guidance clinics were established in the Minneapolis-St. Paul area in 1950 by the Washburn Foundation and in 1954 by the Hamm Foundation.

Until 1950 out-patient psychiatric services were primarily the concern of private organizations. From 1950 to 1952 the state government established four out-patient clinics, two of them in rural areas. No further developments occurred until 1957.

COMMUNITY MENTAL HEALTH SERVICES ACT OF 1957

Under joint sponsorship of the Minnesota Association for Mental Health and the State Department of Public Welfare, the 1957 legislature enacted a Community Mental Health Services Act patterned after the existing New York legislation. In broad language, a state grant-in-aid program was inaugurated, providing up to 50% of opera-

tional costs for community mental health services. Four distinct programs were authorized under this act:

- Establishing new community mental health services.
- Enabling a local community to purchase psychiatric services from a public or private agency.
- Expanding already existing community services.
- Transferring current totally state supported clinics to local community operation.

CURRENT TRENDS

One of the most encouraging outgrowths of this act during its first six months of existence is the spontaneous rural interest. Under provisions of this act, 50,000 is the minimum population recommended for the establishment of an all-purpose community clinic. With approximately 15,000 to 18,000 residents in a typical rural Minnesota county, it has been necessary for counties to unite and develop intercounty cooperation to provide the necessary population base (as shown in Table 1). Grants for the establishment of two mental health centers serving 11 rural counties have been made (Willmar and Crookston). Fourteen additional counties have indicated intent to establish, cooperatively, three rural mental health centers. Two larger counties, each having the necessary population, have received grants under the state aid program (Rochester and Austin). As this is written—during the first six months of the grant-in-aid program—a third of Minnesota's 87 counties are planning local community mental health services.

Another gratifying outgrowth of this act has been the county government's willingness to support financially local out-patient

Minnesota's Services

HODGES AND CAMERON

TABLE 1

LOCATION	NAME OF CLINIC	NUMBER OF COUNTIES SERVED	POPULATION SERVED **	TYPE OF GRANT	SOURCE OF LOCAL FUNDS
Grants made 7/1/57-1/1/58					
Duluth	Duluth Mental Hygiene Clinic	1 *	104,511	Expansion of services	Voluntary
Rochester	Rochester-Olmsted Co. Counseling Clinic	1	50,008	Re-establishment of previous center	Taxes and voluntary contributions
Austin	Mower Co. Mental Health Center	1	47,317	New facility	Taxes
Willmar	West Central Mental Health Center	3	66,526	New facility	Taxes
Crookston	Northwestern Mental Health Center	8	105,228	New facility	Taxes
Minneapolis	Washburn Memorial Clinic	City	521,718	Expansion of services	Private Foundation
St. Paul	Hamm Memorial Psychiatric Clinic	City	311,349	Expansion of services	Private Foundation
Alexandria		7	98,592	Proposed new facility	Taxes (planned)
Albert Lea	Southern Minnesota Mental Health Center	4	101,756	Transfer of state clinic to local operation	Taxes (proposed)
Fergus Falls	Fergus Falls Mental Hygiene Clinic	3	110,845	Transfer of state clinic to local operation	Taxes (proposed)

* Serves primarily Duluth but available to St. Louis County residents.

** Population figures are 1956 estimates by the Minnesota Department of Health.

facilities for their residents. In 28 of the 29 counties currently developing local mental health programs, the entire local financial support is derived from county taxes, the remaining 50% being derived from the state.

SUMMARY

The history of the community mental health program in Minnesota demonstrates the lag which has occurred in rural com-

munities. Prior to 1955 less than 8% of out-patient psychiatric facilities were available to 55% of the state's total population. Since the passage of the Community Mental Health Act in April of 1957 one-third of the counties in Minnesota have indicated intent in applying for state grant-in-aid. Two factors appear prominent in current developments: The process of intercounty cooperation and the willingness of local county government units to contribute local financial support.

BENJAMIN MALZBERG, Ph.D.

Demographic aspects of general paresis

Mental disease, as measured by rates of first admissions to mental hospitals, has been increasing steadily in New York State for many decades. This describes an average result, however, and thereby conceals an opposite trend in certain categories. Chief of these is general paresis, for which rates of first admissions are available since 1911. These rates represent admissions to the civil state hospitals, but since these hospitals include 95% of the admissions with general paresis to all mental hospitals in New York State, public and private, they determine the trend.

Prior to 1920 first admissions with general paresis numbered from 700 to 900 annually and represented approximately 13% of all first admissions. Despite a continuous growth of population, the number of such first admissions fluctuated little up to

1930 and actually decreased subsequently, reaching a minimum after 1950. In conjunction with significant increases in other groups of psychoses, general paresis decreased after 1920 to 2% of the total first admissions.

Table 1 provides smoothed annual rates of first admissions with general paresis for every second year beginning with 1912. The rates were derived from a 3-year moving average. The average annual rate for 1912, for example, is based upon first admissions with general paresis from 1911 to 1913 inclusive.

Dr. Malzberg is the principal research scientist for the Research Foundation for Mental Hygiene, Albany, N. Y., and for the New York State Department of Mental Hygiene. His investigation was supported by a research grant from the National Institute of Mental Health.

TABLE 1

Average annual rates of first admissions with general paresis to all New York civil state hospitals, per 100,000 population, 1912 to 1955

FISCAL YEAR	MALES	FEMALES	TOTAL	FISCAL YEAR	MALES	FEMALES	TOTAL
1912	12.0	4.0	8.0	1936	12.1	3.5	7.8
1914	13.2	3.2	8.2	1938	11.1	3.4	7.3
1916	13.8	3.4	8.6	1940	10.3	3.4	6.9
1918	14.0	3.6	8.8	1942	9.5	3.1	6.2
1920	13.2	3.0	8.1	1944	8.4	2.8	5.5
1922	12.6	2.9	7.7	1946	7.1	2.3	4.6
1924	12.1	2.8	7.8	1948	5.2	1.8	3.4
1926	11.5	2.9	7.2	1950	3.8	1.4	2.6
1928	11.6	3.0	7.3	1952	2.5	1.2	1.8
1930	11.4	3.1	7.3	1954	1.8	0.8	1.3
1932	12.1	3.4	7.8	1955	1.4	0.5	1.0
1934	12.3	3.4	7.8				

Among males the rate rose from 12.0 per 100,000 population in 1912 to 14.0 in 1918. The rate decreased to 11.4 in 1930, then rose to 12.3 in 1934. But since 1934 the rates have decreased without interruption to a minimum of 1.4 in 1955.

Rates for females were at a lower level,

but the trend was similar to that for males. The rate fell from 4.0 in 1912 to 2.8 in 1924, rose to 3.5 in 1936, and then decreased steadily to 0.5 in 1955. Prior to 1950 male rates exceeded those for females in ratios of 3 and 4 to 1. Currently, rates for males are in excess in the ratio of approximately

TABLE 2

Average annual standardized rates of first admissions with general paresis to all hospitals for mental disease in New York State*

PERIOD	MALES	FEMALES	TOTAL
1919-21	21.5 \pm 0.51	4.7 \pm 0.24	12.9 \pm 0.28
1929-31	17.7 \pm 0.41	4.4 \pm 0.21	10.9 \pm 0.23
1939-41	12.9 \pm 0.41	4.2 \pm 0.14	8.4 \pm 0.19
1949-51	3.2 \pm 0.16	1.8 \pm 0.12	3.0 \pm 0.11

* Population of New York State aged 15 years or over on January 1, 1920 (in intervals of 5 years) taken as standard.

Demographic Aspects of General Paresis

MALZBERG

2 to 1. Male rates of first admissions with general paresis have clearly decreased more rapidly than those for females.

A further description of the trend is shown in Table 2. The rates are standardized to remove differences resulting from changes in the age and sex proportions of the general population. The population used as standard was that of New York State aged 15 years or over on January 1, 1920. The rate fell from an annual average of 12.9 per 100,000 in 1919-1921 to 3.0 in 1949-1951. Among males the rate fell in 30 years from 21.5 to 3.2, a decrease of 85%. Among females the rate fell from

4.7 to 1.8, a decrease of 62%, and a verification of the fact that the rate of general paresis fell more rapidly among males.

AGE

There were 1,122 first admissions with general paresis during 1949-51 to all hospitals for mental disease in New York State. Two-thirds of the admissions were within the age range 35 to 59. There was a sex difference in this respect, females being in relative excess at ages under 40. The average age at first admission was 51.4 for males, 47.5 for females, and 50.3 for both sexes.

TABLE 3

First admissions with general paresis to all hospitals for mental disease in New York State, 1949-51, classified according to age

AGE (years)	NUMBER			PERCENT			AVERAGE ANNUAL RATE PER 100,000 POPULATION		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
10-14	5	1	6	0.6	0.3	0.5	0.4	0.1	0.2
15-19	-	9	9	-	2.6	0.8	-	0.7	0.3
20-24	5	7	12	0.6	2.1	1.1	0.3	0.4	0.4
25-29	20	15	35	2.6	4.4	3.1	1.2	0.8	1.0
30-34	25	25	50	3.2	7.3	4.5	1.5	1.3	1.4
35-39	67	49	116	8.6	14.3	10.3	4.0	2.6	3.2
40-44	121	51	172	15.5	14.9	15.3	7.3	2.9	5.1
45-49	108	41	149	13.8	12.0	13.3	7.0	2.6	4.8
50-54	123	42	165	15.8	12.3	14.7	8.4	2.8	5.6
55-59	127	39	166	16.3	11.4	14.8	10.2	3.1	6.7
60-64	80	20	100	10.3	5.8	8.9	7.8	1.9	4.9
65-69	50	20	70	6.4	5.8	6.2	6.6	2.4	4.4
70-74	26	13	39	3.3	3.8	3.4	5.4	2.3	3.7
75-84	19	8	27	2.4	2.3	2.4	4.6	1.4	2.8
85 or over	3	1	4	0.4	0.3	0.4	4.8	1.0	2.4
Unasc.	1	1	2	0.1	0.3	0.2	-	-	-
Total	780	342	1122	100.0	100.0	100.0	3.6	1.5	2.5

The average annual rate grew from less than 1 per 100,000 among those under 20 years of age to a maximum of 6.7 at ages 55 to 59 (see Table 3). The rate grew among males to a maximum of 10.2 at ages 55 to 59. The rates were of a lower order among females, but there was a distinct trend in the sex ratio with advancing age. Through ages 60 to 64 the male rates exceeded those for females in an increasing ratio, which reached 4.10 to 1. As with alcoholic psychoses, this may be related to the high percentage of widowers at the older ages. The incidence of general paresis rises significantly in this group.

The average age at first admission with general paresis has risen since 1920. It rose among males from 44.4 years in 1920 to 51.4 in 1950. Among females the average age increased from 45.1 in 1920 to 47.5 in 1950. This was owing to an increase in the proportion of such first admissions aged 60 or over. In 1920 this age group included 8% of male first admissions with general paresis, and in 1950 the corresponding percentage was 23. Among females the percentages grew from 8 to 18.

In 1930 the average annual rates of first admissions among males exceeded those of 1920 at ages 65 or over. At all other ages, however, the rates for 1920 were in marked excess. A similar pattern occurred in 1940, the rates during that period being less than those for 1930 at all ages up to 65. The downward trend was even more marked in 1950, each age group having a lower rate than the corresponding rate for 1940.

Among females the rates for 1920 exceeded those for 1930 through ages 45 to 49. Beyond that age the rates for 1930 were in excess. With some minor fluctuations the rates for 1940 were less than those for 1930 through ages 50 to 54 but were in excess at higher ages. Between 1940 and 1950 the rates decreased significantly

in all but one age group. The rate of decrease was less, however, than the corresponding ratios among males.

SEX

All statistical studies show that males have higher rates of general paresis than females, though the degree of excess varies. In general the rates for males have decreased more rapidly than those for females, so that the sex ratio has decreased. Since syphilis is the primary cause of general paresis, it appears probable that changing standards of sex mores in recent decades have been a significant factor in reducing the disparity between the sexes in the relative incidence of syphilis.

ENVIRONMENT

The incidence of mental disease varies geographically within the state. In general, the rate is higher in urban areas. Under the definitions used by the Bureau of the Census in 1940 incorporated places with a population of 2,500 or over were considered urban. All others were classified as rural.

On this basis the average annual rate of first admissions with general paresis in New York State during 1949-51 was 1.4 per 100,000 white population. The urban and rural rates were 1.7 and 0.8 respectively.

These rates are affected significantly by the varying distributions with respect to age and sex. Therefore, standardized rates were computed, based upon the age and sex proportions of the general population of New York State aged 15 years or over on April 1, 1950. The resulting rates were 2.1 for the urban areas, 1.0 for the rural areas, and an average of 1.9 for the entire state. New York City had a rate of 2.0 compared with 2.4 for the remaining urban areas, but

Demographic Aspects of General Paresis

MALZBERG

TABLE 4

Average annual rates of first admissions with general paresis to all hospitals for mental disease in New York State, per 100,000 population, 1919-21, 1929-31, 1939-41, 1949-51

MALES								
AGE (years)	1919- 21	1929- 31	1939- 41	1949- 51	b	c	d	d
	-	-	-	-	-	-	-	-
	(a)	(b)	(c)	(d)	a	b	c	a
15-19	0.4	0.4	0.5	-	1.00	1.25	-	-
20-24	1.3	1.2	0.5	0.3	0.92	0.42	0.60	0.23
25-29	6.4	5.7	3.4	1.2	0.89	0.60	0.35	0.19
30-34	20.8	18.2	12.1	1.5	0.88	0.66	0.12	0.07
35-39	39.4	28.6	19.4	4.0	0.73	0.68	0.21	0.10
40-44	45.2	34.1	23.5	7.3	0.75	0.69	0.31	0.16
45-49	42.4	34.0	24.9	7.0	0.80	0.73	0.28	0.17
50-54	35.6	33.4	25.1	8.4	0.94	0.75	0.33	0.24
55-59	28.1	23.6	20.1	10.2	0.84	0.85	0.51	0.36
60-64	23.4	19.3	16.4	7.8	0.82	0.84	0.48	0.33
65-69	10.8	13.0	15.3	6.6	1.20	1.18	0.43	0.61
70-74	1.5	5.8	8.9	5.4	3.87	1.53	0.61	3.60
75 or over	1.1	5.1	6.8	4.6	4.64	1.33	0.68	4.18

FEMALES								
AGE (years)	1919- 21	1929- 31	1939- 41	1949- 51	b	c	d	d
	-	-	-	-	-	-	-	-
	(a)	(b)	(c)	(d)	a	b	c	a
15-19	0.4	0.4	0.9	0.7	1.00	2.25	0.78	1.75
20-24	1.3	0.9	0.7	0.4	0.69	0.78	0.57	0.31
25-29	2.8	2.4	2.4	0.8	0.86	1.00	0.33	0.29
30-34	5.4	4.0	4.8	1.3	0.74	1.20	0.27	0.24
35-39	7.9	7.5	6.7	2.6	0.94	0.89	0.39	0.33
40-44	9.1	8.6	7.0	2.9	0.94	0.81	0.41	0.32
45-49	9.0	8.1	6.5	2.6	0.90	0.80	0.40	0.29
50-54	7.9	8.2	6.1	2.8	1.04	0.74	0.46	0.35
55-59	4.3	5.7	5.9	3.1	1.33	1.04	0.53	0.72
60-64	1.4	3.7	5.7	1.9	2.64	1.54	0.33	1.36
65-69	0.6	3.5	3.5	2.4	5.83	1.00	0.69	4.00
70-74	-	1.0	2.3	2.3	-	2.30	1.00	-
75 or over	-	1.0	1.8	1.4	-	1.80	0.78	-

TABLE 5

Average annual rates of first admissions with general paresis, per 100,000 white population, to all hospitals for mental disease in New York State, 1949-51, classified according to urban-rural environment

ENVIRONMENT	CRUDE			STANDARDIZED *		
	Males	Females	Total	Males	Females	Total
New York State	2.1 \pm 0.12	0.8 \pm 0.07	1.4 \pm 0.67	2.8 \pm 0.16	1.1 \pm 0.10	1.9 \pm 0.09
Urban	2.4 \pm 0.14	0.9 \pm 0.08	1.7 \pm 0.08	3.1 \pm 0.18	1.2 \pm 0.11	2.1 \pm 0.11
New York City	2.4 \pm 0.18	0.8 \pm 0.10	1.6 \pm 0.10	3.0 \pm 0.22	1.0 \pm 0.12	2.0 \pm 0.13
Other	2.7 \pm 0.26	1.1 \pm 0.16	1.9 \pm 0.15	3.5 \pm 0.33	1.4 \pm 0.20	2.4 \pm 0.19
Rural	1.0 \pm 0.18	0.4 \pm 0.11	0.8 \pm 0.11	1.4 \pm 0.24	0.7 \pm 0.17	1.0 \pm 0.14
Farm	0.9 \pm 0.37	0.4 \pm 0.26	0.7 \pm 0.24	**	**	**
Non-farm	1.1 \pm 0.21	0.4 \pm 0.13	0.8 \pm 0.13	1.4 \pm 0.28	0.7 \pm 0.61	1.1 \pm 0.17

* Population of New York State aged 15 years or over on April 1, 1950 (in intervals of 5 years) taken as standard.

** Not computed.

TABLE 6

Average annual rates of first admissions with general paresis to all hospitals for mental disease in New York State, 1949-51, per 100,000 white population, classified according to age, sex and environment

AGE (years)	URBAN			RURAL		
	Males	Females	Ratio	Males	Females	Ratio
15-19	-	0.6	-	-	0.8	-
20-24	0.1	0.2	0.50	-	-	-
25-29	0.1	0.1	1.00	1.0	-	-
30-34	0.5	0.4	1.25	-	-	-
35-39	1.4	1.1	1.27	0.9	0.6	1.50
40-44	3.7	1.7	2.18	2.9	1.0	2.90
45-49	5.3	2.1	2.52	1.4	1.2	1.17
50-54	5.9	1.9	3.11	2.3	0.8	2.88
55-59	7.6	2.4	3.17	4.0	2.3	1.74
60-64	7.4	1.6	4.63	2.6	1.1	2.36
65-69	4.7	1.5	3.13	2.6	1.3	2.00
70-74	5.2	1.8	2.89	0.9	-	-
75 or over	5.3	0.8	6.63	-	-	-

Demographic Aspects of General Paresis

MAIZBERG

TABLE 7

Average annual rates of first admissions with general paresis, to all hospitals for mental disease in New York State, 1949-51, per 100,000 white population, classified according to age and environment

AGE (years)	MALES			FEMALES		
	Urban	Rural	Ratio	Urban	Rural	Ratio
15-19	-	-	-	0.6	0.8	0.75
20-24	0.1	-	-	0.2	-	-
25-29	0.1	1.0	0.10	0.1	-	-
30-34	0.5	-	-	0.4	-	-
35-39	1.4	0.9	1.56	1.1	0.6	1.83
40-44	3.7	2.9	1.28	1.7	1.0	1.70
45-49	5.3	1.4	3.79	2.1	1.2	1.75
50-54	5.9	2.3	2.57	1.9	0.8	2.38
55-59	7.6	4.0	1.90	2.4	2.3	1.04
60-64	7.4	2.6	2.84	1.6	1.1	1.45
65-69	4.7	2.6	1.81	1.5	1.3	1.15
70-74	5.2	0.9	5.78	1.8	-	-
75 or over	5.3	-	-	0.8	-	-

the difference is not significant. There were too few first admissions with general paresis from the farm population to provide a standardized rate, but it is not likely that the incidence differed significantly from that for the non-farm population.

In general, general paresis, as measured by rates of first admissions, is more frequent among the urban populations. The relative difference between males and females increased significantly in urban areas with advancing age. A corresponding trend cannot be established in rural areas because of random fluctuations in rates, resulting from small numbers of such admissions.

MARITAL STATUS

The rate of first admissions with general paresis varies in relation to marital status.

The rate was lowest among the married—1.4 per 100,000. It rose to 1.8 among the single and to 3.3 among the widowed. The rates were highest among the separated, 9.1, and the divorced, 8.3. Males had higher rates than females in each marital category.

The several marital groups differ widely in their composition with respect to age and sex proportions. Hence, Table 8 includes standardized rates, the standard population being that of New York State aged 15 years or over on April 1, 1950. It is evident that the rate is lowest among the married and highest among the separated and divorced. There was a marked relative increase in the rate for the unmarried. The sex difference in rates is relatively greatest among the single.

Marriage acts selectively. In dementia praecox the selection is based largely upon

TABLE 8

*Rates of first admissions with general paresis
to all hospitals for mental disease in New York State, 1949-51
per 100,000 white population,
classified according to marital status*

MARITAL STATUS	CRUDE RATES *			STANDARDIZED RATES **		
	Males	Females	Total	Males	Females	Total
Single	2.6 ± 0.30	0.8 ± 0.17	1.8 ± 0.18	6.3 ± 0.46	1.2 ± 0.21	3.7 ± 0.26
Married	2.1 ± 0.17	0.8 ± 0.10	1.4 ± 0.10	1.7 ± 0.15	0.7 ± 0.10	1.2 ± 0.09
Widowed	7.0 ± 1.15	2.1 ± 0.37	3.3 ± 0.40	4.0 ± 0.87	2.4 ± 0.40	3.2 ± 0.40
Separated	14.8 ± 3.01	5.0 ± 1.47	9.1 ± 1.52	11.0 ± 2.60	4.1 ± 1.33	7.4 ± 1.37
Divorced	15.4 ± 3.67	3.9 ± 1.44	8.3 ± 1.66	11.8 ± 3.22	3.4 ± 1.34	7.4 ± 1.57

* Based upon corresponding general white population aged 15 years or over.

** Population of New York State aged 15 years or over on April 1, 1950 (intervals of 5 years) taken as standard.

inherent personality characteristics. There is a different kind of selection, however, in connection with general paresis. The unmarried include an unknown proportion who have developed a syphilitic disease and are therefore either deterred from or limited in their opportunities for marriage. The married benefit, in general, from the stabilizing influences of matrimony. In addition, syphilitic mental diseases remain low in frequency among the married because those who have developed such diseases are likely to have shifted previously to the categories of separated and divorced.

Unlike those with alcoholic psychoses, first admissions with general paresis show no trend in the ratio of rates among the single and the married in relation to advancing age (see Table 9). This is owing, in part, to the fact that maximum rates of such psychoses occur at a later age among the married than among the single. The

widowed had a higher rate than the married. Widows, in fact, had a higher rate than unmarried females.

ECONOMIC STATUS

First admissions to mental hospitals are defined as follows with respect to economic status: "Dependent means lacking in the necessities of life or receiving aid from public funds or persons outside the immediate family. Marginal means living on earnings but accumulating little or nothing, being on the margin between self-support and dependency. Comfortable means having accumulated resources sufficient to maintain self or family for at least four months."¹

On this basis, white first admissions with general paresis during 1949-51 were classified as follows: dependent, 22.4%; marginal, 63.6%; comfortable, 11.1%. This distribution approximates closely that for the alcoholic psychoses but includes a significantly lower percentage in the comfortable class than do the manic-depressive or involutional psychoses.

¹ New York State Department of Mental Hygiene. *Statistical Guide*. (12th ed.) Utica, State Hospitals Press, 1943, 52.

Demographic Aspects of General Paræsis

MALZBERG

TABLE 9

Ratio of average annual rates of white first admissions with general paresis to all hospitals for mental disease in New York State, 1949-51, of the single to the married

AGE (years)	MALES			FEMALES		
	Single	Married	Ratio	Single	Married	Ratio
15-19	-	-	-	0.7	-	-
20-24	-	-	-	0.1	0.2	0.50
25-29	0.6	0.1	6.00	0.3	-	-
30-34	1.4	-	-	-	0.3	-
35-39	3.0	0.9	3.33	1.4	0.9	1.56
40-44	5.2	3.0	1.73	3.8	0.7	5.43
45-49	9.6	3.1	3.10	1.3	1.5	0.87
50-54	15.0	2.7	5.56	2.8	0.8	3.50
55-59	21.1	4.1	5.14	0.8	2.3	0.34
60-64	10.2	4.6	2.22	1.0	0.7	1.43
65-69	12.1	2.4	5.04	-	1.1	-
70-74	4.6	2.7	1.70	3.0	1.1	2.73
75 or over	7.2	1.4	5.14	-	-	-

TABLE 10

*Average annual rates of white male first admissions * with general paresis to all hospitals for mental disease in New York State, 1949-51, per 100,000 of selected occupational groups*

OCCUPATION	AGE (YEARS)									
	Total	18-19	20-24	25-29	30-34	35-44	45-54	55-59	60-64	65 or over
Professional, technical etc.	1.1	-	-	-	-	1.2	1.7	4.0	3.8	-
Farmers and farm managers	1.4	-	-	-	-	-	3.3	-	7.0	-
Managers, officials, etc.	1.3	-	-	-	-	0.9	2.3	1.7	1.6	1.9
Clerical and kindred workers	1.6	-	-	-	0.8	1.6	3.3	2.9	2.1	7.1
Service workers, except private household	5.3	-	-	-	-	5.2	6.4	11.4	13.1	3.5
Laborers, except farm and mine	10.5	-	-	1.2	2.7	9.1	22.1	34.4	7.9	11.4
Total labor force*	3.4	-	0.1	0.3	0.4	2.7	5.6	8.4	8.7	10.6

* Aged 14 years or over.

Rates of first admissions cannot be computed on this basis, however, because of the lack of a corresponding classification of the general population. We may approximate such rates by considering occupational groups, since economic status varies with occupation.

The census of 1950 classified the employed population by age and occupation. In classifying the first admissions according to occupation, use was made of the guide prepared by the Bureau of the Census. There is undoubtedly some degree of misclassification, since we cannot be certain that census enumerators and hospital staff always classified in the same manner. Nevertheless, the rates vary to such a degree as to suggest reliability of the differences.

Table 10 gives average annual rates of first admissions with general paresis among selected occupational groups of white males. Some groups, such as the professional, belong to a high economic category. Others,

such as laborers, belong to a lower economic class. The average rate for the total male labor force was 3.4 per 100,000. The professional group had a rate of 1.1, whereas laborers had a rate of 10.5. Service workers (barbers, janitors, waiters and similar groups) had a rate of 5.3. The managerial group had a rate of 1.3; farmers and farm managers, 1.4; and clerical workers, 1.6. There is a definite trend, the rate of first admissions with general paresis being a minimum at the highest economic level and rising to a maximum in the laboring group. With some minor fluctuations this pattern is repeated in each age group.

Occupational statistics for females are not so significant as those for males, since a large proportion of females are not in the labor force. Nevertheless, some significant differences appear in Table 11. White females engaged in professional or technical pursuits had an average annual rate of 0.2 per 100,000. Clerical workers also had a rate of 0.2. The highest rate,

TABLE 11

Average annual rates of white female first admissions with general paresis to all hospitals for mental disease in New York State, 1949-51, per 100,000 of selected occupational groups*

OCCUPATION	AGE (YEARS)									
	Total	18-19	20-24	25-29	30-34	35-44	45-54	55-59	60-64	65 or over
Professional, technical, etc.	0.2	-	-	-	-	-	-	2.2	-	-
Clerical and kindred workers	0.2	-	-	-	-	0.3	0.4	3.8	-	-
Private household workers	3.3	-	-	-	-	5.8	6.0	4.0	4.2	-
Service workers, except private household	1.9	-	-	-	-	5.7	2.8	-	-	-
Total labor force*	3.5	2.7	0.2	0.2	1.2	3.8	5.4	9.0	7.4	14.8

* Aged 14 years or over.

Demographic Aspects of General Paresis

MALZBERG

3.3, occurred among private household workers (domestic servants).

It is clear therefore that, in general, rates of first admissions are low in occupations that rank high in the economic scale and are highest at the other end of the economic scale. This is undoubtedly associated with a further class and economic differentiation in the spread of syphilis.

EDUCATION

The census of 1950 classified the general population according to degree of formal education. This was defined as the highest grade completed. For our purposes we began at age 25, since formal education may be assumed to have been completed by this age. First admissions with general paresis were classified similarly according to degree of education. The reporting with respect to highest grade included so large a proportion of unascertained cases, however, that it was necessary to use broad classes: no education, elementary school, high school, college. First admissions who could neither read nor write were included with those having no education.

Crude rates of first admissions with general paresis are summarized for the white

population in Table 12 according to degree of education. There is an inverse relation, the rates decreasing from a maximum of 7.1 per 100,000 among those with no education to a minimum of 0.7 among those with a college education. Rates were higher for males than for females, but each sex showed the same inverse relation between degree of education and rate of first admissions. Among males the rate decreased from 12.4 to 1.2 with advancing degrees of education. Among females the corresponding rates were 3.0 and 0.2 respectively.

Age specific rates of first admissions are shown in Table 13. With but a few minor exceptions those with no education had higher rates of first admissions than each of the other educational groups in the several age classes. Similarly, those with some degree of elementary education exceeded those with a high school or college education, and the high school group, in turn, exceeded the college group.

It is clear therefore that the rate of first admissions with general paresis varies inversely with the degree of education. But does this imply association or causation? Those with a low degree of education include a significantly higher percentage of

TABLE 12

White first admissions aged 25 years or over with general paresis to all hospitals for mental disease in New York State, 1949-51, classified according to degree of education

DEGREE OF EDUCATION	NUMBER			AVERAGE ANNUAL RATES PER 100,000 OF CORRESPONDING POPULATION		
	Males	Females	Total	Males	Females	Total
None	50	16	66	12.4 ± 2.04	3.0 ± 0.88	7.1 ± 1.02
Elementary school	226	97	323	4.4 ± 0.34	1.8 ± 0.16	3.0 ± 0.20
High school	80	43	123	1.8 ± 0.23	0.8 ± 0.14	1.2 ± 0.13
College	25	1	26	1.2 ± 0.28	0.2 ± 0.13	0.7 ± 0.16

TABLE 13

Rates of first admissions among white first admissions with general paresis to all hospitals for mental disease in New York State, 1949-51, per 100,000 of corresponding population, classified according to age and degree of education

MALES										
AGE (years)	DEGREE OF EDUCATION									
	None	Elementary	High	College	a	a	a	b	b	c
	(a)	(b)	(c)	(d)	-	-	-	-	-	-
25-29	-	0.8	0.2	-	-	-	-	4.00	-	-
30-34	10.4	0.9	0.2	-	11.56	52.00	-	4.50	-	-
35-39	-	2.5	1.0	0.7	-	-	-	2.50	3.57	1.43
40-44	6.4	4.6	2.6	3.2	1.39	2.46	2.00	1.77	1.44	0.81
45-54	11.7	6.4	3.4	1.0	1.83	3.44	11.70	1.88	6.40	3.40
55-64	19.0	5.9	3.3	2.9	3.22	5.76	6.55	1.79	2.03	1.14
65-74	9.5	2.6	3.3	4.3	3.64	2.88	2.21	0.79	0.60	0.77
75 or over	8.9	2.1	2.9	-	4.24	3.07	-	0.72	-	-

FEMALES										
AGE (years)	DEGREE OF EDUCATION									
	None	Elementary	High	College	a	a	a	b	b	c
	(a)	(b)	(c)	(d)	-	-	-	-	-	-
25-29	-	-	0.1	-	-	-	-	-	-	-
30-34	8.6	0.5	0.2	0.4	17.20	43.00	21.50	2.50	1.25	0.50
35-39	6.7	1.6	0.6	-	4.19	11.17	-	2.67	-	-
40-44	-	2.2	1.6	-	-	-	-	1.38	-	-
45-54	6.3	2.3	1.2	-	2.74	5.25	-	1.92	-	-
55-64	2.2	2.2	2.0	-	1.00	1.10	-	1.10	-	-
65-74	2.2	1.5	0.3	-	1.47	7.33	-	5.00	-	-
75 or over	1.9	0.8	-	-	2.38	-	-	-	-	-

foreign-born than those with higher degrees of education. They also include a higher percentage in dependent economic circumstances. Both nativity and economic status are related to the differential incidence of mental disease. Thus, low degrees of formal education are related indirectly to high

rates of first admissions with general paresis, through association with other social factors, primarily migration and economic status.

RACE

Racial comparisons of the incidence of general paresis in New York State must be

Demographic Aspects of General Paresis

MAIZBERG

limited primarily to the white and Negro populations. These are the only racial aggregates that are described in sufficient detail in the census of population.

There were 475 Negro first admissions with general paresis during the 3-year period 1949-51, for an average annual rate of 17.2 per 100,000 Negroes. The rate rose, in general, with advancing age to a maximum of 55.4 at ages 55 to 59 (see Table 14). Among males the rate grew to a maximum of 89.6 at ages 55 to 59, with an average annual rate of 24.8 for all male Negroes. Among females the rate rose to a maximum of 25.0 at ages 50 to 54, with an average

rate of 10.8 for all female Negroes. The male rate exceeded the female rate in the ratio of 2.3 to 1. The relative excess of the males grew from 12% at ages 20 to 24 to almost 300% at ages 55 to 59.

Between 1930 and 1940 the average annual rate of first admissions with general paresis grew among Negroes from 25.0 to 33.9. Between 1940 and 1950, however, there was a significant decline to 17.2, a decrease of 49%. The decrease occurred in all age intervals. In general, though the rates for males exceeded those for females, the former declined more rapidly during the decade. Between ages 25 and 55 the rates

TABLE 14

Negro first admissions with general paresis to all hospitals for mental disease in New York State, 1949-51, classified according to age

AGE (years)	NUMBER			PERCENT			AVERAGE ANNUAL RATE PER 100,000 NEGRO POPULATION		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
10-14	3	1	4	1.0	0.6	0.8	3.4	1.1	2.2
15-19	-	-	-	-	-	-	-	-	-
20-24	4	5	9	1.3	3.1	1.9	3.8	3.4	3.6
25-29	16	14	30	5.1	8.6	6.3	11.9	8.1	9.7
30-34	19	19	38	6.1	11.7	8.0	16.0	12.1	13.7
35-39	45	32	77	14.4	19.8	16.2	38.4	21.1	28.6
40-44	63	25	88	20.1	15.4	18.5	61.5	20.7	39.4
45-49	37	13	50	11.8	8.0	10.5	41.1	13.1	26.4
50-54	45	18	63	14.4	11.1	13.3	64.5	25.0	44.4
55-59	40	11	51	12.8	6.8	10.7	89.6	23.2	55.4
60-64	15	5	20	4.8	3.1	4.2	50.4	14.1	30.7
65-69	17	8	25	5.4	4.9	5.3	78.1	27.1	48.8
70-74	5	5	10	1.6	3.1	2.1	41.6	30.0	34.9
75-84	3	4	7	1.0	2.5	1.5	38.6	24.7	31.8
85 or over	1	1	2	0.3	0.6	0.4	66.7	33.0	44.1
Unascert.	-	1	1	-	0.6	0.2	-	-	-
Total	313	162	475	100.0	100.0	100.0	24.8	10.8	17.2

TABLE 15

Average annual rates of first admissions with general paresis among Negroes to all hospitals for mental disease in New York State, per 100,000 corresponding population, 1949-51 and 1939-41

AGE (years)	AVERAGE ANNUAL RATE 1949-51			AVERAGE ANNUAL RATE 1939-41			RATIO		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
15-19	-	-	-	4.9	2.8	3.8	-	-	-
20-24	3.8	3.4	3.6	3.4	4.3	3.9	1.12	0.79	0.92
25-29	11.9	8.1	9.7	27.9	13.5	19.7	0.43	0.60	0.49
30-34	16.0	12.1	13.7	78.7	20.1	45.7	0.20	0.60	0.30
35-39	38.4	21.1	28.6	91.8	23.3	54.7	0.42	0.91	0.52
40-44	61.5	20.7	39.4	78.0	33.4	55.4	0.79	0.62	0.71
45-49	41.1	13.1	26.4	134.0	35.1	84.1	0.31	0.37	0.31
50-54	64.5	25.0	44.4	143.1	26.7	83.4	0.45	0.94	0.53
55-59	89.6	23.2	55.4	101.1	36.3	67.4	0.89	0.64	0.82
60-64	50.4	14.1	30.7	95.1	65.1	79.4	0.53	0.22	0.39
65-69	78.1	27.1	48.8	119.7	21.0	63.6	0.65	1.29	0.77
70 or over	42.3	29.4	34.4	85.4	13.4	41.2	0.50	2.19	0.83
Total	24.8	10.8	17.2	54.5	10.4	33.9	0.46	0.66	0.51

declined by approximately 50% to 60%. The rate of decrease was less at older ages. Among females the rates declined during the decade by approximately 40% up to age 45. At ages 50 to 64 they declined by smaller amounts and showed increases instead of decreases at ages above 65 years.

The white population had an average annual rate of 1.5 per 100,000 population. Males and females had rates of 2.2 and 0.8 respectively. In 1940 the white population had a rate of 5.8, indicating a decrease of 74% during the following decade, compared with a decrease of 49% among Negroes. Thus, though both whites and Negroes had declining rates of general paresis, the decrease was more rapid among whites, so that the relative excess of Negroes over whites increased during the decade.

The Negro population is relatively younger than the white population, a fact which influences the relative incidence of general paresis. Standardized rates are therefore given in Table 18. The population used as standard with respect to age and sex distributions was that of the State of New York aged 15 years or over on April 1, 1950.

The standardized rate for Negroes fell from 49.4 in 1940 to 26.7 in 1950, a decrease of 46%. The decrease was more marked among males, the rate falling from 77.6 to 38.6, a decrease of 50%. The standardized rate fell by only 36% among Negro females—from 23.4 to 14.9. The rate for males was in excess in 1940 in the ratio of 3.32 to 1. In 1950 the ratio was reduced to 2.59 to 1.

Among whites the standardized rate declined from 7.4 in 1940 to 1.9 in 1950, a

Demographic Aspects of General Paresis

MALZBERG

TABLE 16

Average annual rates of first admissions with general paresis among whites to all hospitals for mental disease in New York State, per 100,000 corresponding population, 1949-51 and 1939-41

AGE (years)	AVERAGE ANNUAL RATE 1949-51			AVERAGE ANNUAL RATE 1939-41			RATIO		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
15-19	-	0.6	0.3	0.4	0.8	0.6	-	0.75	0.50
20-24	0.1	0.1	0.1	0.4	0.5	0.4	0.25	0.20	0.25
25-29	0.3	0.1	0.2	2.1	1.7	1.9	0.14	0.06	0.11
30-34	0.4	0.4	0.4	8.6	3.7	6.1	0.04	0.11	0.07
35-39	1.3	1.0	1.2	14.7	5.6	10.2	0.09	0.18	0.12
40-44	3.6	1.5	2.5	20.4	5.6	13.1	0.18	0.27	0.19
45-49	4.5	1.9	3.2	20.2	3.3	12.9	0.22	0.58	0.24
50-54	5.3	1.7	3.4	21.4	5.4	13.7	0.24	0.31	0.24
55-59	6.9	2.3	4.6	17.8	4.0	11.5	0.39	0.58	0.40
60-64	6.4	1.5	4.0	14.8	4.3	9.4	0.43	0.34	0.43
65-69	4.2	1.4	2.8	13.2	3.1	7.9	0.32	0.45	0.35
70 or over	4.0	1.0	2.3	6.6	1.9	4.0	0.61	0.53	0.58
Total	2.2	0.8	1.5	8.8	2.8	5.8	0.25	0.29	0.26

TABLE 17

Average annual rates of first admissions with general paresis among Negroes and whites to all hospitals for mental disease in New York State, 1949-51, per 100,000 corresponding population

AGE (years)	AVERAGE ANNUAL RATE AMONG NEGROES			AVERAGE ANNUAL RATE AMONG WHITES			RATIO		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
15-19	-	-	-	-	0.6	0.3	-	-	-
20-24	3.8	3.4	3.6	0.1	0.1	0.1	38.00	34.00	36.00
25-29	11.9	8.1	9.7	0.3	0.1	0.2	39.67	81.00	48.50
30-34	16.0	12.1	13.7	0.4	0.4	0.4	40.00	30.25	34.25
35-39	38.4	21.1	28.6	1.3	1.0	1.2	29.54	21.00	23.83
40-44	61.5	20.7	39.4	3.6	1.5	2.5	17.08	13.80	15.76
45-49	41.1	13.1	26.4	4.5	1.9	3.2	9.13	6.89	8.25
50-54	64.5	25.0	44.4	5.3	1.7	3.4	12.17	14.71	13.06
55-59	89.6	23.2	55.4	6.9	2.3	4.6	12.99	10.09	12.04
60-64	50.4	14.1	30.7	6.4	1.5	4.0	7.88	9.40	7.68
65-69	78.1	27.1	48.8	4.2	1.4	2.8	18.60	19.36	17.43
70 or over	42.3	29.4	34.4	4.0	1.0	2.3	10.58	29.40	14.96
Total	24.8	10.8	17.2	2.2	0.8	1.5	11.27	13.50	11.47

TABLE 18

Average annual standardized rates of first admissions with general paresis to all hospitals for mental disease in New York State, per 100,000 population, 1949-51 and 1939-41, classified according to race*

	NEGRO			WHITE			RATIO OF NEGRO TO WHITE	
	1950 (a)	1940 (b)	$\frac{a}{b}$	1950 (a)	1940 (b)	$\frac{a}{b}$	1950	1940
Males	38.6 \pm 2.36	77.6 \pm 4.20	0.50	2.8 \pm 0.16	11.9 \pm 0.33	0.24	13.79	6.52
Females	14.9 \pm 1.33	23.4 \pm 2.08	0.64	1.1 \pm 0.10	3.4 \pm 0.17	0.32	13.54	6.88
Total	26.7 \pm 1.32	49.4 \pm 2.24	0.54	1.9 \pm 0.09	7.4 \pm 0.18	0.26	14.05	6.68

* Population of New York State aged 15 years or over on April 1, 1950 (in intervals of five years) taken as standard.

reduction of 74%, compared with 46% among Negroes. The rate for males decreased by 76%, from 11.9 to 2.8. The rate decreased among white females from 3.4 to 1.1, a decrease of 68%. Thus, as with Negroes there was a relatively greater decrease among males than females. In 1940 the rates for males and females were in the ratio of 3.50 to 1. In 1950 they were in the ratio of 2.54 to 1.

Though the standardized rates of first admissions with general paresis decreased among both whites and Negroes, the relative excess of the Negro rate increased during the decade because of the more rapid decline among whites. In 1940 the Negro rate was in excess in the ratio of 6.68 to 1. This grew to 14.05 to 1 in 1950.

It is clear therefore that there has been progress in the prevention of syphilitic mental disease among Negroes since 1940. Compared to the white population, however, there is still need for greater preventive endeavors. Greater control of syphilis and prompt treatment to prevent subsequent infections of the central nervous system re-

main necessities of a sound program of public health.

Table 19 includes statistics of first admissions with general paresis among several major racial or ethnic divisions of the white population. It is not possible, however, to compute rates of first admissions because corresponding data for the general population are not available. We may note, however, that 20% of all white first admissions with general paresis were Italians, compared with only 6.9% for the Irish. In the case of the alcoholic psychoses, the corresponding percentages were 3.9 and 25.2 respectively. Despite the absence of basic census data showing the numbers of Italian and Irish parentage, it is highly probable that such large differences must be statistically significant.

There were 33 Jewish first admissions with general paresis, or 5.3% of the white total. Jews represented only 1% of all white first admissions with alcoholic psychoses. It is possible to estimate the incidence of general paresis among Jews. It is believed, on the

Demographic Aspects of General Paresis

MALZBERG

TABLE 19

White first admissions with general paresis to all hospitals for mental disease in New York State, 1949-51, classified according to race

RACE	NUMBER			PERCENT		
	Males	Females	Total	Males	Females	Total
Jewish	27	6	33	6.1	3.4	5.3
Irish	29	14	43	6.5	7.9	6.9
Italian	110	15	125	24.8	8.4	20.1
Scandinavian	9	2	11	2.0	1.1	1.8
Slavonic	28	8	36	6.3	4.5	5.8
Other	240	133	373	54.2	74.7	60.1
Total	443	178	621	100.0	100.0	100.0

basis of conservative estimates, that Jews represented 15% of the white population of New York State in 1950.² On this basis there were 2,080,000 Jews in New York State and 11,791,000 non-Jewish whites. The average annual rates of first admissions with general paresis were 0.5 per 100,000 Jews and 1.7 per 100,000 white non-Jews. This may be considered a significant difference in view of the fact that the estimate of the Jewish population is almost certainly too low and thereby exaggerates the rate for Jews. While low, in general, it also appears that Jews have a significantly higher rate of general paresis than of alcoholic psychoses.

NATIVITY

The average annual rate of first admissions with general paresis in New York State during 1949-51 was 1.1 per 100,000 population for the native white population and 3.1 for the foreign-born whites. For males the rates were 1.5 and 5.2 for the native and foreign-born respectively. For females they were 0.8 and 1.1 respectively.

The rates were influenced strongly by the age distributions of the native and foreign-born. The latter include a smaller proportion of the very young (*i.e.*, under age 20), among whom general paresis is relatively rare. Hence, it is necessary to make exact age comparisons. Table 20 shows that in all but one age group native white males had lower rates than foreign-born white males. Among females, however, the rates were higher for the natives at almost all ages. When standardized on the basis of the age distribution of the general population of New York State aged 15 years or over on April 1, 1950, the rates were 1.8 for the native and 1.9 for the foreign-born whites, a difference lacking statistical significance. On the basis of crude rates the foreign-born white males were in excess in the ratio of 3.47 to 1. On the basis of standardized rates this was reduced to a ratio of 1.20 to 1. Despite the small difference, it might be considered significant in view of the fact

² *Yivo Annual of Jewish Social Science*. 10(1955), 282.

TABLE 20

Average annual rates of first admissions with general paresis to all hospitals for mental disease in New York State, 1949-51, per 100,000 white population, classified according to nativity

AGE (years)	MALES			FEMALES		
	Native	Foreign-born	Ratio	Native	Foreign-born	Ratio
15-19	-	-	-	0.6	2.8	0.21
20-24	0.1	-	-	0.1	1.2	0.08
25-29	0.3	-	-	0.1	-	-
30-34	0.4	-	-	0.4	-	-
35-39	1.6	-	-	1.2	-	-
40-44	3.5	3.9	0.90	1.8	0.5	3.60
45-49	5.1	3.7	1.38	2.2	1.3	1.69
50-54	5.2	5.7	0.91	1.9	1.4	1.36
55-59	5.2	9.7	0.54	2.7	1.9	1.42
60-64	5.1	8.0	0.64	2.1	0.7	3.00
65-69	2.7	5.5	0.49	1.8	1.1	1.64
70 or over	3.2	5.2	0.62	0.6	1.7	0.35

TABLE 21

Average annual rates of first admissions with general paresis to all hospitals for mental disease in New York State, 1949-51, per 100,000 white population, classified according to nativity and parentage

NATIVITY AND PARENTAGE	CRUDE			STANDARDIZED *		
	Males	Females	Total	Males	Females	Total
Native	1.5 ± 0.11	0.8 ± 0.08	1.1 ± 0.07	2.5 ± 0.17	1.2 ± 0.11	1.8 ± 0.10
of native parentage	1.2 ± 0.13	0.6 ± 0.09	0.9 ± 0.08	2.2 ± 0.22	1.1 ± 0.14	1.6 ± 0.13
of mixed parentage	2.4 ± 0.54	1.4 ± 0.31	1.9 ± 0.26	4.4 ± 0.68	2.2 ± 0.44	3.3 ± 0.40
of foreign parentage	1.9 ± 0.24	0.8 ± 0.15	1.4 ± 0.15	2.8 ± 0.31	1.1 ± 0.19	1.9 ± 0.18
Foreign-born	5.2 ± 0.44	1.1 ± 0.20	3.1 ± 0.24	3.0 ± 0.33	1.0 ± 0.19	1.9 ± 0.19
Total	2.1 ± 0.12	0.8 ± 0.07	1.4 ± 0.07	2.8 ± 0.16	1.1 ± 0.10	1.9 ± 0.09

* Population of New York State aged 15 years or over on April 1, 1950 (in intervals of 5 years) taken as standard.

Demographic Aspects of General Paresis

MALZBERG

TABLE 22

Average annual rates of first admissions with general paresis to all hospitals for mental disease in New York State, 1949-51, per 100,000 native white population, classified according to age and parentage

AGE (years)	MALES					
	of native parentage (a)	of mixed parentage (b)	of foreign parentage (c)	$\frac{b}{a}$	$\frac{b}{c}$	$\frac{c}{a}$
15-19	-	-	-	-	-	-
20-24	0.1	-	-	-	-	-
25-29	0.5	-	-	-	-	-
30-34	0.1	1.4	0.5	14.00	2.80	5.00
35-39	2.0	3.4	0.7	1.70	4.86	0.35
40-44	3.7	6.4	2.7	1.73	2.37	0.73
45-49	5.6	8.4	3.3	1.50	2.54	0.59
50-54	4.5	10.5	4.6	2.33	2.28	1.02
55-59	2.6	5.8	9.4	2.73	0.62	3.62
60-64	3.7	9.2	6.7	2.49	1.37	1.81
65-69	1.3	7.1	4.3	5.46	1.65	3.31
70 or over	1.9	4.0	6.0	2.11	0.67	3.16

AGE (years)	FEMALES					
	of native parentage (a)	of mixed parentage (b)	of foreign parentage (c)	$\frac{b}{a}$	$\frac{b}{c}$	$\frac{c}{a}$
15-19	0.5	1.5	-	3.00	-	-
20-24	0.1	-	-	-	-	-
25-29	-	0.6	-	-	-	-
30-34	0.5	1.3	-	2.60	-	-
35-39	1.3	3.0	0.6	2.31	5.00	0.46
40-44	2.0	4.1	1.0	2.05	4.00	0.50
45-49	2.0	2.8	2.3	1.40	1.22	1.15
50-54	2.0	2.0	1.7	1.00	1.17	0.85
55-59	2.2	3.4	3.2	1.54	1.06	1.45
60-64	1.2	4.3	3.2	3.58	1.34	2.67
65-69	1.1	3.5	2.5	3.18	1.40	2.27
70 or over	0.4	1.3	0.4	3.25	3.25	1.00

that the rates for the foreign-born males were consistently in excess in all but one age group. The reverse is the case for females, however, the standardized rates

being 1.0 for the foreign-born compared with 1.2 for the natives, rates for the latter being in excess at all ages from 25 to 65.

Since the incidence of general paresis

varies with the degree of urbanization, it is probable that the rates for the foreign-born would be reduced still further if corrections were made for such concentration of population.³ We must conclude therefore that general paresis, a consequence of syphilis, is at least not significantly greater in incidence among the foreign-born males, and in the case of females is probably less frequent among the foreign-born.

PARENTAGE

The native white population may be divided into three groups on the basis of parentage. Those of native parentage had an average annual rate of first admissions with general paresis of 0.9 per 100,000 corresponding population. Native whites of foreign parentage had a rate of 1.4. Native whites of mixed parentage (one parent native, the other foreign-born) had a rate of 1.9.

The crude rates are influenced, however, by the differential distributions with respect to age. Almost half of the natives of native parentage were under 20 years of age, compared with less than 10% of those of foreign parentage. Natives of mixed parentage had the highest percentage in the age groups characteristic of general paresis. Therefore the preceding comparisons must be adjusted with respect to age.

The rates were standardized on the basis of the age and sex distributions of the general population of New York State on April 1, 1950 aged 15 years or over. On this basis the average annual rates were as follows: of native parentage, 1.6; of mixed parentage, 3.3; of foreign parentage, 1.9. According to definitions employed by the Bureau of the Census, natives were also considered of mixed parentage if the nativity of one parent was known and the nativity of the other was unknown. Some who were

so classified probably belonged to the other nativity groups. When the nativity of both parents was unknown it was assumed in the preceding comparisons that they were foreign-born. Hence, there is a possibility that some first admissions were classified incorrectly as of foreign parentage.

Nevertheless, the differences in specific age rates of first admissions are so large (see Table 22) that it may be concluded that they point in the correct direction. That is, native whites of native parentage had the lowest rate of general paresis and native whites of mixed parentage had the highest rate. The difference between native whites of native parentage and those of foreign parentage is not statistically significant.

The most striking difference is that between native white males of foreign parentage and those of mixed parentage. Their standardized rates were 2.8 and 4.4 respectively. Males of foreign birth also had a lower rate than natives of mixed parentage. The implication is that those with a uniform social origin as measured by similar backgrounds of nativity are likely to have more closely knit family relations, which is a form of social prophylaxis.

SUMMARY

1. For several decades there has been a steady, significant decrease in the annual rates of first admissions with general paresis.
2. The rate declined for both males and females, but more rapidly for the former.
3. Males have higher rates of first admissions than females, the relative disparity in such rates increasing with advancing age.

³ Benjamin Malzberg, "Mental Disease among the Native and Foreign-born White Populations of New York State, 1939-41," *Mental Hygiene*, 39(4, 1955), 545-63.

Demographic Aspects of General Paresis

MALZBERG

4. The average age of first admissions with general paresis has risen since 1920 and is owing to an increase in such first admissions aged 60 years or over.

5. General paresis is more prevalent in urban than in rural areas. The excess of the male rate is relatively greater in urban areas and increases with advancing age.

6. General paresis is least prevalent among the married, and the rates are highest among the separated and the divorced. The widowed have higher rates than the married.

7. First admissions with general paresis have higher percentages classified as in dependent or marginal economic status than other groups of mental disorders, such as manic-depressive. Rates of first admissions according to occupational groupings show that those in high economic categories have low rates of general paresis and that those in low economic categories have high rates.

8. The rate of first admissions with general paresis varies inversely with degree of education. Those with no or little formal education have higher rates than those with varying degrees of higher education. The differences are closely associated with differences in economic status.

9. The rate of first admissions with general paresis decreased by almost 50% among Ne-

groes between 1940 and 1950. The rate decreased more rapidly among males than females.

10. This is the first time since the beginning of heavy Negro migration to New York State that the rate of first admissions with general paresis has decreased among Negroes.

11. The rate also decreased among the white population but at a greater rate than among Negroes. As a result the Negro rate exceeded the rate for whites in the ratio of 14.05 to 1, compared with a ratio of 6.68 to 1 in 1940.

12. Jews had a lower crude rate of general paresis than the remaining white population of New York State.

13. It is probable that those of Italian origin had a higher rate of general paresis than the Irish in New York State.

14. Foreign white females had a lower rate of general paresis than native white females. There was no significant difference among males.

15. Native whites of native parentage had a lower rate of first admissions with general paresis than foreign-born whites. They also had lower rates than native whites of either foreign or mixed parentage. The latter had the highest rate.

Book Reviews

CURRENT PRACTICES IN MENTAL HOSPITAL ADMINISTRATION

By the American Psychiatric Association
Mental Hospital Service

Washington, American Psychiatric Association, 1958.

One need only review the contents to know that this is an outstanding collection of articles (previously published in *Mental Hospitals*) by some of the foremost mental hospital administrators of our times. Lest the neophyte gain the impression that this is the answer to mental hospital administration, however, one must pay serious attention to Dr. Overholser's preface, which advises that although "the contents do not completely cover the field, an attempt has been made to deal with essential points in each category." It is the hope of the chairman of the APA committee on certification of mental hospital administrators that the publication may not only prove to be instructive in a field where material is altogether too sparse, but that it will illustrate the varied satisfactions that mental hospital administration as a field has to offer to a number of people.

Granted that a number of articles are profoundly basic (this has been deliberate in order to appeal to all levels of mental hospital personnel), bear in mind that it is not intended to represent the end product in mental hospital administration guidance, for there are a number of problems that are not touched upon. Those that are included are written in excellent fashion, readily comprehensible and, as such, are highly recommended to all those dealing in the mental hospital field. Particularly gratifying are the comprehensive bibliographies at the end of each article, so that ready references are available to all who diligently peruse its contents. Any person displaying

interest in this area, irrespective of his profession, can acquire a wealth of information and insight in plant operation, training programs, public relations, team approach, job definitions—to mention a few is to do an injustice to the others.

From Chapter 1 by Dan Blain through to its termination this small booklet is thoroughly enjoyable and should be required reading for any candidate who intends to pursue this field and particularly for those who anticipate facing the APA committee of examiners on certification of mental hospital administration.—ROBERT S. GARBER, M.D., New Jersey Neuro-Psychiatric Institute.

PREVENTION OF CHRONIC ILLNESS

Volume I: Chronic Illness in the United States

By the Commission on Chronic Illness

Cambridge, Harvard University Press, 1957. 338 pp.

This first volume of a group of studies by the chronic disease task force gives indication of the tremendous job that has been done and will be done in this study. Although much of the material is not new or startling, the availability of such in textbook form will be of considerable importance, not only to provide an approach to handling such illness but also to assist a variety of individual operations which could benefit from cooperative work. Since the problem of the task force was global, both in numbers and kinds of illnesses, the report contains many generalities but also pulls together material not easily available elsewhere.

Those in the field of mental health might feel that their interests were slighted because the proportion of the material devoted

to mental health does not seem as great as the total problem. The material is clear and succinct but there is very little new about the mental health area either in prevention or in therapeutic needs. To this extent those chapters concerning mental health are valuable mostly in terms of the comprehensive statement of current approaches. The work of this commission is perhaps better spelled out in a chapter entitled "The Emotional Aspects of Chronic Illness." This chapter makes clear the current feelings about the effect of mental health on many other illnesses.

Subsequent volumes will make this series a valuable compendium in an area of medical care which both clinically and economically demands attention.—HENRY H. WORK, M.D., University of California School of Medicine.

PRINCIPLES OF PERCEPTION

By S. Howard Bartley

New York, Harper & Brothers, 1958. 482 pp.

"It is probable that the person who gets great enjoyment out of his senses—that is, gets pleasure out of the sheer sensuous impact of his surroundings—is in pretty good mental health" (p. 459). Thus concludes Professor Bartley at the end of his investigation of the *scientific* aspects of perception. The book will be disappointing to those for whom "perception" is the current magic word (as "semantics" was not too long ago). For Professor Bartley is an experimental psychologist whose primary field of interest has been vision, and he has little patience with poorly defined terms. He points out that there has been little attempt to agree on definitions, and suggests one of his own which would differentiate between the cognitive and thinking processes on

the one hand and perception on the other:

"That perception is definable is another conclusion. To use the word and save any of its ordinary meaning, the most logical and useful primary procedure is to divide human activity into two vast categories. The first is the behavior that follows closely upon stimulation, a behavior that is immediately available for response to the come-and-go of impingements upon it. The second category includes all activity that succeeds the first—the aftermath and sequel to perceptual response. . . . It is by definition, for example, that perception can be said to be discriminatory" (p. 450).

He reviews in detail the experiments on perception—in such detail, in fact, that the non-experimentalist is apt to become impatient with him. After finishing the book, however, I am convinced that this is a necessary discipline for anyone concerned with perceptual processes. In fact, a strong case might be made for this as required reading for all who have any pretense at professional psychological competency. It should make us more self-conscious in the use of such an emotionally loaded word—make us cautious in its undefined use.

From the standpoint of the general reader one could wish that the last few chapters had been expanded, but Bartley himself would say that he has done about all that the *scientist* can do at this point, that there is already too much speculation on limited facts in the everyday applications of the principles of perception. What he does say, however, suggests some of the almost limitless possibilities of research in this field. The implications for education, psychotherapy, etc., are exciting, to say the least, but the leap is pretty broad that leads from experimentally validated perceptual hypothesis to the practical applications of those theories.

So although he only suggests some of the

more practical aspects of the subject, he lays a pretty firm foundation for the necessary steps to a more secure application and helps us to see the incomplete structure undergirding much of our thinking in this field. The psychotherapist, the mental hygienist and all others dealing with the practical problems of human behavior should have this as a basic reference on their shelves—and turn to it now and then just to refresh their minds on just how *scientific* some of their thinking is.

There are two rather disappointing aspects of the book, however, which should be mentioned in passing. There are a surprising number of misprints in the book (as where a reference to "white mice" comes out "white noise"—and other obvious misspellings). And the author is apparently completely unaware of the existence of the subjunctive. One cannot expect a psychologist to be a grammarian, but the editors should have caught him at least part of the time. And the Harper imprint has usually guaranteed good proofreading. While these flaws do not invalidate the book, they take away some of the pleasure in its reading.—W. EDGAR GREGORY, M.D., College of the Pacific School of Education.

THE NATURE AND TRANSMISSION OF THE GENETIC AND CULTURAL CHARACTERISTICS OF HUMAN POPULATIONS

Papers presented at the 1956 annual conference of the Milbank Memorial Fund

New York, Milbank Memorial Fund, 1957. 143 pp.

The ten papers in this volume are organized under three headings. The first section, entitled Factors Influencing the Characteristics of Populations, includes three papers which raise questions of general interest

with emphasis on the complexity of interrelationship of the genetic and cultural factors. In the second part, Identification, Distribution and Fertility of People with Variant Characteristics, three article reporting on specific studies are preceded by one on the significance of tests in such studies. The third group of papers is entitled Research on Genetic Factors in Characteristics of Populations. Here there are three papers on current research problems in these fields.

All articles represent thoughtful efforts to avoid bias, and the authors stress the fact that cultural and genetic forces operate together. Dr. Theodore Dobzhansky, discussing the biological concept of heredity as applied to man, warns that the demonstration that hereditary factors affect a trait does not exclude the possibility that environmental factors contribute, and also that the degree to which hereditary or environmental factors operate will vary according to time, place and material studied. Dr. Gordon Allen points out in discussing the genetic aspects of mental disorder that an hereditary basis for behavioral phenomena may be satisfactorily demonstrated before anatomical correlates can be found and, conversely, the presence of an anatomical or biochemical correlate is not necessarily proof of genetic variation—as in some studies of genetics and schizophrenia.

Related to this statement of Dr. Allen's is a question brought to mind by Dr. Dudley Kirk's paper on the fertility of a gifted group. Could it be that a common factor such as having been reared in a small family contributed to the success of these men as well as to their tendency to produce small families?

It is remarkable that no consideration is given in these papers to the potential contribution here, unwieldy as it may be, of

psychoanalytic thinking. The powerful impact of emotional factors, conscious and unconscious attitudes, etc., goes unremarked except in the broadest cultural terms. The inclusion of one paper on a study proceeding from this direction would have added a valuable dimension. Perhaps such an effort may become part of the extensive twin studies outlined by Dr. Frank Falkner in the final article.—ALICE R. CORNELISON, Yale University School of Medicine.

NEW FRONTIERS OF AGING

Wilma Donahue and Clark Tibbitts, eds.
Ann Arbor, University of Michigan, 1957. 209 pp.

The New Frontiers of Aging is a comprehensive study of the ever-increasing problems in the care of the older portion of the population. The treatise provides informative and instructive reading, especially for those engaged in social science, social service and the care and rehabilitation of the aged.

This book would be a valuable adjunct to any library. Each chapter, written by a recognized authority in his particular field, supplies many tables of comparative figures, making the book also a very handy and convenient reference tool.

The constantly increasing and widespread adoption of automation in industry has in the last few years added greatly, and will add more so in the future, to the difficulty of the older worker in continuing his employment. This factor is perhaps the most disruptive element that can destroy the morale of the aging person, who is still able to work but deprived of the opportunity of doing so. This problem is masterfully treated in the chapter on automation, which clearly points out the pressing necessity of further study and research.

The areas of present endeavor are fully

explored and new avenues of development and further study are suggested. The interest of the reader is not allowed to wane as each particular facet of the problem is considered in turn.

The Scandinavian countries have always been considered well advanced in social welfare, and the chapter devoted to them affords an interesting glimpse into how they handle the problem of proper and adequate housing for the aged.

As administrative head of a home for the aged housing over 300 men and women I find much in the book that I can advantageously use in working out the problems that daily confront me. And I can highly recommend it to the attention of those who work with and are interested in the welfare of our elder citizens.

Congratulations to both Mr. Tibbitts and Dr. Donahue for their splendid work on *The New Frontiers of Aging*.—MOTHER M. BERNADETTE DE LOURDES, Mary Manning Walsh Home, New York City.

YOUTH AND CRIME

Proceedings of the Law Enforcement Institute held in 1955 at New York University
Frank J. Cohen, ed.

New York, International Universities Press, 1957. 273 pp.

This report by a group of socially minded citizens working on pre-adult behavior problems is well worth reading, particularly at this time when there is so much concern about juvenile delinquency.

The focus of the report is how to help our law enforcement agents do a more effective job in coping with youthful offenders. It is emphasized by nearly all speakers that this is a multi-faceted problem, and that the law enforcement officer is only one member of the community team which

must function as an integrated unit if an effective job is to be done. L. Bender, reporting on 20 years' experience with disturbed children at Bellevue Hospital, finds six factors contributing to the problem: Pathological identification resulting from broken homes, disturbed parents, etc.; conflicts resulting from cultural attitudes on the role of male and female in our society; social discrimination because of race, color or creed; learning difficulties; organic brain disease; latent or mild schizophrenia. She also points out that the incidence of hardcore juvenile delinquency has been about the same for the last hundred years and that more research, particularly longitudinal studies, is necessary.

The need for more money for legal, social and psychological facilities and for better integration of these facilities is stressed, as well as a firmer and a less permissive attitude on the part of law enforcement officers.

The former attorney general of New York, the Honorable Jacob K. Javits, was chairman of the New York State Youth Commission, the Honorable Mark A. McCloskey, and the director of the Law Enforcement Institute, Dr. Frank J. Cohen, are to be commended for sponsoring and organizing an institute of this nature. The problem is complex and pressing, and this type of report contributes to the understanding which is necessary for action.—LEWIS I. SHARP, M.D., New York City.

THE PATIENT AND THE MENTAL HOSPITAL

Milton Greenblatt, Daniel J. Levinson and Richard H. Williams, eds.

Glencoe, Ill., Free Press, 1957. 658 pp.

In recent years it has become increasingly evident that all is not well with our public

mental hospitals. Deutsch pointed out some striking discrepancies in the performance of the hospitals in the 1930's as compared with that in the 1830's and 1840's. Bateman and his colleagues studied the mental hospital as a society and Sewall and the sociologists from Duke University examined some of the standard procedures in the Veterans Administration hospitals. They found that many current practices are, in fact, quite anti-therapeutic and have certainly contributed to the accumulation of chronic patients and the resulting necessity for continual expansion of hospitals.

The present book, which is the edited transcript of a research conference on socio-environmental aspects of patient care in mental hospitals, documents many questionable practices and suggests plans which may lead to correction. It is substantially a report of studies and research going on in the field. There are 49 contributors, representing the disciplines of psychiatry, psychology, social science, anthropology, nursing and biometrics. The book is divided into four sections (each opening with a general statement) dealing with four aspects of care: Organization, therapeutic personnel, the ward and the extra-hospital world. The final chapter summarizes the conference and ongoing efforts in this field from the viewpoint of hospital practice, systematic theory and research. Dr. Harry C. Solomon has contributed a thoughtful foreword.

The book loses a bit in its impact because it is rather too long and contains a number of highly technical statistical papers which will be unintelligible to many readers. Also, to this reviewer, the conference and book would have been improved by contributions by more mental hospital administrators who have actually fought the battle of the budget with the Congress or a legislature.

These objections are rather insignificant,

however, in view of the tremendous importance of most of the papers, which report studies and research complete or in progress. The fresh, non-traditional approach of the social scientists as described here has proved to be amazingly fruitful both in developing new ideas and insights and in actually starting new programs of action. It would be discriminatory to discuss the merits and demerits of the various papers, even if space permitted. This reviewer found those dealing with administration and nursing problems most rewarding, which doubtless reflects his own particular interests. Others will find equally provocative material such as that on role images, family relationships and cultural attitudes. The section titled "What Is Therapy and Who Does It" is well worth everyone's attention.

There is a beginning here of a revolutionary period in mental hospital practice. While it has been partially obscured by the explosive advent of drug therapy, the total effect will likely be more far-reaching. The two together may well spell the welcome demise of the state hospital as we know it.

I am sure this volume will be read and re-read and discussed for a long time.—
GRANVILLE L. JONES, M.D., Little Rock State Hospital.

THE CHILD IN THE EDUCATIVE PROCESS

By Daniel A. Prescott

New York, McGraw-Hill Book Co., 1957. 502 pp.

The Child in the Educative Process describes a 3-year program of child study activities, illustrating its main features in case histories. Dr. Prescott emphasizes the impact of concrete classroom occurrences upon the particular youngster under dis-

cussion, and shows the important role played by the teacher.

His sound understanding of the educative process is demonstrated throughout this volume by the author's sensitivity to such matters as interpersonal relationships, the emotional climate of the classroom and the factor of ego involvement of the individual child. Knowledge gained from the child study program of the Institute for Child Study of the University of Maryland is also discussed.

Dr. Prescott presents his subject in a challenging manner. The reader is confronted with more issues about classroom problems and child development than are ordinarily considered in a single book. The result is that he finds himself involved in a creative reading experience in which he can begin at almost any place in the book and absorb much valuable information.—
ARTHUR LERNER, Los Angeles City College.

SCHIZOPHRENIA: SOMATIC ASPECTS

Derek Richter, ed.

New York, Macmillan Company, 1957. 181 pp.

This valuable book is the outcome of a meeting at Ciba Foundation in London for the purpose of reassessing the present knowledge of somatic aspects of schizophrenia. The first of the nine papers appearing in this small volume is one by L. Rees on the physical characteristics of schizophrenia patients. It is followed by one on the interaction of genetic and environmental factors in the causation of schizophrenia by M. Roth. Both of these presentations consider the data of Kallman and the more recent findings of Slater pertaining to the genetic factor in schizophrenia. The influence of the physical status of the patient and the environmental factors which seem

to be of significance in the precipitation of the illness are reviewed critically. The difficulties of a simple generalization in genetic terms are pointed out. D. Hill writes on the use of the electroencephalogram in schizophrenia. Though routine EEG records have been somewhat disappointing, the possibility of using such records in experimental situations and following the administration of known biochemical substances still looks inviting. Throughout these three papers the implication of maturation processes in schizophrenia are entertained.

The biochemical aspects of schizophrenia are covered by D. Richter, endocrine changes by D. E. Sands. The material in these two papers reflects most clearly the difficulty of correlating biochemical data with what is agreed to be a heterogeneous group of conditions. In addition to the influence of the emotional state of the individual on the determinations made, there is the question of whether the findings are of etiologic significance or are only variations which occur as an outcome of the disease.

A paper on the metabolism of recurrent schizophrenia by L. H. Rey reviews principally the works of Gjessing and of Rowntree and Kay. The data, though applicable to a small group of patients, contributes to our knowledge of the biochemical changes undergone by this group. In a paper on the pathological anatomy of the schizophrenias, G. B. David covers quite extensively the literature, which consists largely of negative findings. There are, however, some suggestions of a semi-permanent, histologically demonstrable metabolic dysfunction of the neurohormones of the diencephalon. S. Sherwood presents a comparison of experimental neurophysiological findings to schizophrenia symptoms in his paper on consciousness, adaptive behavior and schizophrenia. His contribution is

provocative and looks optimistically to the future. The final paper—on drug action in schizophrenia by Dr. Stafford-Clark—reviews in part the presently more fashionable toxic theories in the causation of schizophrenia.

In an over-all view of the material presented in this book, there is no doubt that the genetic evidence is impressive. The concept of stress and its implications in terms of physical and/or psychological factors precipitating schizophrenia is emphasized. Though the possible production of a toxic agent resulting from stress in a group of subjects with a specific genetic constitution is inviting, there still remains the consideration of neural organizations and their adaptive capacities.—FRED ELMADJIAN, M.D. Worcester State Hospital.

THE MIND OF THE MURDERER

By W. Lindesay Neustatter

New York, Philosophical Library, 1957. 232 pp.

The Mind of the Murderer is written for the lay reader. In 16 chapters the author gives accounts of killers he studied directly or through newspaper reports. We meet "Christie—The Hysteric" who strangled numerous women; "Ley—The Paranoiac" who worked for years in a law firm, then entered politics and planned a grisly murder by proxy; "Neville Heath—The Psychopathic Sadist" whose revolting butcheries shocked the British public. The style is descriptive, and Dr. Neustatter includes lengthy transcripts of court proceedings and medical examinations. The appendix gives the entire Homicide Bill recently introduced in England and Wales; under Clause 2 murder convictions can be changed to manslaughter if the killer was suffering from "an abnormality of the mind."

Some of the murderers described in this book clearly suffer from mental illness. But more often than not the psychiatric findings are ambiguous and a judge or jury would have difficulty in applying Clause 2. The author states "there is a lack of objective tests in mental illness to establish a diagnosis, which frequently is a matter of opinion" (p. 186). He purposely avoids analyzing the motives which lie behind the homicides. Perhaps the act of murder itself should constitute an "objective test" of emotional disturbance, and the concern with squeezing criminals into nosologic categories which were established for patients in mental hospitals be abandoned. Indeed, when Dr. Neustatter asks "was he an hysterical psychopath, a schizophrenic, or a plain liar?" (p. 222) he precludes an answer. In these and similar questions the author has scrambled the technical terms used by physicians with words that have differing connotations for the lay reader.

Although his case material is fascinating, Dr. Neustatter's book does not merit a recommendation to the serious students of criminology.—PETER F. OSTWALD, M.D., University of California Medical Center.

REMOTIVATING THE MENTAL PATIENT

By Otto von Mering and Stanley H. King
New York, Russell Sage Foundation, 1957. 216 pp.

This a timely, well written book soberly pointing up the renewed attack on mental illness, not only by the current chemical and somatic therapies but by the training and stimulation of hospital personnel to create an appropriate milieu that will remotivate the mental patient—even the lobotomy cases and the old, long-time chronically ill. Dr. von Mering, an anthropologist, and Dr.

King, a social psychologist, focus "on the possibilities that exist within the social situation for an improved understanding of the patient and new outlooks for his rehabilitation." They relate some of the courageous and promising attempts to resolve the hospital population situation, despite budget and staff problems, and to reverse the philosophy of pessimism of cure for individuals committed to public mental hospitals. The problems are awesome when one considers that only 40% of patients admitted to state institutions are discharged in a 5-year period, that the average stay is 8 years, and that 27% of all new admissions have senile psychosis or cerebral arteriosclerosis.

The authors point out that the rigidity of social classification of ward patients—"sitters," "onlookers," "doctor chasers"—precludes exploring attitudes toward the treatment of long-term patients. Also, how the term "chronic" alters staff expectation into implicit acceptance of hopelessness, helps patients become unknown entities populating a ward, and supports staff inaction. They point out the varieties of care with such words as "museum ward," "moving ward," "family ward," and the drawbacks.

Interesting chapters, with happy titles, describe ways in which remotivation has been put into practice in a variety of wards and in many different hospitals. The chapter on the habit-training ward points up toilet care as a basic ingredient in changing apathy and discouragement to optimism. The chapter on the house of miracles describes how much can be done with post-lobotomy patients and an orientation program for the relatives, "pushing gently but not shoving." The chapter on the family of elders deals with the hard core of patients—the senile group. The authors show the effect of ward mothers upon the sizable numbers of hospital population who

work in the hospital, and show how the security achieved often makes the difference between continued hospitalization and discharge.

Again and again the authors emphasize the need for a "conscious recognition of the steps in remotivation, all the way from marked regression to discharge," as incorporated into the total effort and program. Aides must be made part of the treatment team. Staff must participate in the patient society. Within the patient group, the sick can help the sicker. Every attempt should be made to introduce activities in the ward—activities that are as normal as possible and oriented toward future life outside. Encouraging programs can be developed in spite of many real difficulties.

A profound respect for the individual, for individual treatment and goals is a constant theme in the book, and a worthy reminder to all who have to deal with large numbers of the mentally sick. This book should be read by all disciplines working with the emotionally disturbed. The authors and the Russell Sage Foundation sponsoring this study are to be congratulated for a meaningful contribution and a heartening message to all workers in the field of mental health.—JOSEPH D. TEICHER, M.D., Child Guidance Clinic of Los Angeles.

PSYCHOPHYSIOLOGIC MEDICINE

By Eugene Ziskind, M.D.

Philadelphia, Lea & Febiger, 1954. 370 pp.

This book actually contains two elements: a report of the operations of the training program in psychophysiologic medicine at the Cedars of Lebanon Hospital in Los Angeles, and a practical guide to the reasonably sophisticated general practitioner who wishes to learn better ways of dealing

with the emotional problems of his patients. Though the first element is implicit, it obviously has contributed greatly to the development and presentation of the second—and the reader will be impressed by both.

Achieving harmony in the collaborative efforts of "a group of psychiatrists of different orientations—psychoanalysts, psychobiologists and electics—in a unified program" is a worthy undertaking in itself. (It would be interesting to know more about the horizontal communication problems and their solution.) In such a situation, many authors would weary and confuse the reader by cross-references and explanations designed to place the various "schools" in proper relationship one to the other. The author has courageously and lucidly concentrated on "what is common to most psychiatric thinking," leaving the differences and deviations to a special section of the book.

With this excellent philosophy Dr. Ziskind has produced a practical, down-to-earth book which steers a beautifully sane course between the patronizing attitude displayed by many "courses for the general practitioner" and the oversimplified, offhand manner of do-it-yourself treatises on psychotherapy. Nowhere is there any attempt to gloss over the difficulties; instead, the author offers directions and examples where these are appropriate and suggests intuitive or commonsense approaches where specific guidance is not indicated or possible. It is difficult to imagine a physician (or a medical student) who would not find the book interesting and useful.

Perhaps the outstanding characteristic of the work is the fact that it constantly emphasizes the basic position of the physician, relating all matters of technique (history-taking, therapy, etc.) to his customary activities rather than implying that he should

learn a brand-new orientation. In a few areas there may be disagreement; for example, this reviewer is inclined to feel that judicious medication can be used more frequently to support both the usual role of the physician and the psychotherapy which may be his main tool. Also, some physicians are sure to be disappointed that there is not some factual discussion of the problem of charging patients for the longer periods of time required for psychotherapy.

The last section in the book, which deals with the schools of psychiatric thought, probably will have less practical significance to the practicing physician but should diminish a great deal of the undignified confusion resulting from the doctrinaire and cultist pronouncements which—unfortunately—make up much of present-day psychiatric literature. For medical students, this wise and tolerant presentation should be required reading.

One can confidently predict an enthusiastic reception for this badly needed and well-written volume. Its very practicality forces one slight criticism: The subject index is poorly arranged and the subjects seem rather distantly related to the material listed under them. Improvement of this area in the editions which will be sure to follow will make the book even more useful than it is in its present form.—C. H. HARDIN BRANCH, M.D., University of Utah Department of Psychiatry.

MENTAL DEFICIENCY

By L. T. Hilliard and
Brian H. Kirman

Boston, Little, Brown & Company, 1957. 517 pp.

This book is the product of two British psychiatrists who have specialized in the

field of mental deficiency. They have collaborated with a team of two psychologists, an occupational therapist and a neuropathologist to produce a volume which is outstanding for its stress on the social and clinical aspects of this field of psychiatry.

The text is divided into three main sections. The first deals with the general problem of mental deficiency, including its legal, social, etiological and psychological phases. The second section is devoted to problems of the mentally handicapped individual in various phases of his development and includes chapters on educationally subnormal, uneducable, physically handicapped and mentally disturbed children. The third section reviews the present possibilities of treatment and training with emphasis on employment and rehabilitation.

The authors are to be commended for unusual objectivity and thoroughness in presenting a wealth of well-documented references in all sections of this work. Controversial subjects such as confusing terminology and classification, as well as conflicting theories of etiology, diagnosis and treatment are handled skillfully. Special consideration is placed on the importance of home care wherever possible for the mentally handicapped child. The necessity of a prolonged observation of the child and adequate assessment of his intellectual resources before institutionalization is stressed.

The chapter on neuropathology is well illustrated with many photographs of gross and microscopic sections of various disease entities. An abundance of well-chosen clinical case reports and photographs is generously interspersed throughout the book. These serve to maintain the authors' main theme that mental defect is a wide social problem rather than merely a separate branch of clinical medicine. As a minor

criticism, some of the newer aspects of treatment in such diseases as phenylketonuria and Wilson's disease do not receive adequate attention. It is hoped that a future volume will correct these deficiencies. The last chapter of advice to parents is especially well written and includes the statement, "It is now generally appreciated that in dealing with many problems of children it is more important to treat the parent than the child. This is particularly true of the defective child."

Although the book is oriented toward mental deficiency services available in Britain and is heavily influenced by the National Health Service Act, its clarity, completeness and objectivity make it an excellent source of information. This volume is highly recommended not only for physicians but also for social workers, psychologists, teachers and others concerned with the welfare of the mentally handicapped individual.—LEO KANNER, M.D., and ALLAN SCHWARTZBERG, M.D., Johns Hopkins Hospital.

THE MOON IS FULL

By Aileen Adair

New York, Philosophical Library, 1957. 200 pp.

In this candid and frankly illuminating volume the author poses the question: How much of "lunacy" prevails in the minds and hearts of the "sane" as they go about their everyday businesses and professions in search of personal rewards and the well-being of their fellowmen?

The reviewer feels that Dr. Adair's work is too telescopic and much too comprehensive for a brief *critique*.

As for background, the author was the daughter of a medical superintendent of a

mental hospital in the British Isles. In her youthful years she was more devoted to the perusal of medical literature than to the diversions of Grimm's fairy tales.

The Moon Is Full deals with practical problems in the treatment of the mentally ill and the mentally deficient. Incidentally, the author displays an unusual degree of sympathy and understanding with the problems of the latter.

Her case histories are abundant and well chosen. They illustrate specific illnesses, their legal aspects, treatment efforts and the effects of institutional morale. Interpersonal relationships of staff are highlighted in terms of their effect upon patient treatment. Recruitment problems seem to be influenced by the same factors as those prevalent in the U. S.—namely, program, prestige and salary.

Since the author reveals her own conflicts, her story is one of personal as well as professional experience and struggle. Her account is recommended to all persons interested in advancing their own knowledge and in improving the standards of the care and treatment of the mentally ill and deficient.—MARYAN BRUGGER CURINA, Illinois Association for Mental Health.

HELPING THE VISUALLY HANDICAPPED CHILD IN A REGULAR CLASS

By Anthony J. Pelone

New York, Teachers College, Columbia University 1957. 99 pp.

The school administrator who is faced with the problem of providing educational facilities and services for a child who is handicapped because of a severe visual defect

will find Dr. Pelone's book a worthwhile addition to his library.

In a most interesting and readable manner the author defines the degrees of visual handicaps, explores current thinking as to the most satisfactory methods of educating visually handicapped children, and explains in considerable detail the provisions of a recently amended federal act intended to promote education of the blind.

In his chapter on the partially seeing child in the regular class the author explains the ways in which the visually handicapped child differs from his peers and—even more important—points out their many similarities. The unique needs of the totally blind child attending the regular class are described in a separate chapter. The role of the itinerant teacher as an active member of the team working with the blind child is also discussed.

The three appendices, which give a fairly complete glossary of eye terms and suggested lists of equipment and materials (with commercial sources) for partially seeing and blind children attending regular classes, add to the value of this book as a ready reference for the school administrator and his staff.

This book might well be called *Understanding and Accepting the Visually Handicapped Child in the Regular Class*. It could be utilized as a handbook and guide for the coordinator of special educational services of a school system, since the author describes in a concise manner the role of each member of the school team who should be concerned with the visually handicapped child's satisfactory integration in the regular class setting. Indeed, even the parents of a blind or visually handicapped child who attends the regular class will find this well-written book informative and comforting.—JANE ANDERSON MACCALLUM, New York State Education Department.

PIERRE THE PELICAN

New revised and extended series

Messages 1 to 28

By Loyd W. Rowland, Ph.D.

New Orleans, Louisiana Association for Mental Health, 1957.

At a time when so much effort has been directed toward the detection or correction of mental and emotional illness it is encouraging to observe the shifting emphasis of the parent educator, the pediatrician and the psychiatrist toward what public health calls primary prevention or, more specifically, positive mental health. A foremost leader in this effort over the years has been Dr. Loyd W. Rowland, director of the Louisiana Association for Mental Health, and his highly successful *Pierre the Pelican* series of messages to the parents of first-born children.

This series of friendly, warm and helpful talks with parents has now been extended over a period of six years of the child's life. Twenty-eight pamphlets, humorously illustrated and featuring *Pierre the Pelican*, the symbol of wise counseling, is intended for distribution to parents once monthly during the child's first year, every other month during the second year, every fourth month during the third and fourth year, and every six months during the fifth and sixth year.

The basic concept featured throughout this series is what is now commonly called "anticipatory guidance." This term was first employed by Dr. Julius Levy, formerly with the New Jersey State Department of Health, who pointed out that behavior patterns of children were often quite normal or natural, even though frequently thought of or described as problems by parents and often by the medical profession. He further appreciated that the parents' attitudes toward these events in the early weeks and

months of infancy make up the environment which forms the basis of the child's developing personality. Accordingly, by being helped to anticipate situations and certain types of conduct, parents were better able to acquire desirable attitudes toward their children's behavior at various developmental periods and to use more desirable methods of dealing with them. In a sense, then, this series of messages helps parents to acquire the attitudes and understanding about their first child and themselves which they might with good fortune have acquired only after having had several children.

The use of repetition, the appeal to the experience of parents themselves, the simplified material and vocabulary, and the use of a mythical character Pierre contributes to making direct advice more palatable and acceptable. In this way, certain basic principles of child care have been emphasized. These include the importance of the parent as a teaching example, family affection and child acceptance, the process of maturation and readiness, individual differences, the enjoyment of learning, the acceptance of individual limitations, and the seeking after causes of behavior.

It is apparent that not only may parents benefit from the simple, relaxed, conversational manner used throughout the series, but that professional persons can learn to adopt a similar non-dogmatic, non-authoritarian approach in their work with children and parents. Teachers, public health nurses and physicians would be particularly urged to study the language and approach used in these pamphlets, in order to increase the effectiveness of their communication, lessen anxiety and increase their empathy.

Pierre is a very wise bird indeed for having demonstrated a practical way of preventing or lessening some of the forces that might otherwise lead to mental or emotional imbalance, and of improving the attitudes

and behavior of parents toward their children in the direction of mental health. How much we all need his advice!—GEOFFREY W. Estry, M.D., New Jersey State Department of Health.

THE GUILTY AND THE INNOCENT; MY 50 YEARS AT THE OLD BAILEY

By William Bixley

New York, Philosophical Library, 1957. 176 pp.

William Bixley is described only as a "supervisory official of Old Bailey"—his exact role being nowhere defined. Apparently he was a court attendant. Here, he reminisces about the dramatic trials held at that court. He smacks his lips over the sadistic activities of some of the defendants, but is devoid of any grasp of the meaningful implications of such behavior. He recites the strange antics of strange law-breakers in a casual anecdotal way, and assigns moralistic value judgments. For example "brutish monster guilty of murder" or "the slave of monstrous lusts"; "a strange brooding look in her eyes that betokened madness" or "they are all gutless when the inevitable punishment is administered"; "unprincipled and amoral rogue," and so on. Mr. Bixley's psychiatric naïveté is remarkable. Thus, he says that one obviously paranoid defendant would have won a little sympathy if only he had given sound evidence to justify his suspicions—apparently taking the position that psychotic people should reason sanely about their delusions.

The stories shuttle back and forth without any order, and the author often forgets to make clear the dates of the various events. The book is poorly bound, the paper pulpy and the illustrations non-illustrative. (For instance, the only picture of Old Bailey itself is dated 1841!) In all,

this slim volume provides an evening of light and passive reading for a light and passive reader.—HENRY A. DAVIDSON, M.D., Overbrook Hospital, Cedar Grove, N. J.

PRESCRIPTION FOR SURVIVAL

By Brock Chisholm

New York, Columbia University Press, 1957. 92 pp.

Today more people than ever are aware that we all live in one world. Many people have become sophisticated in the complexities of what determines human behavior. More people than ever before are also acquainted with the changing trends in human affairs throughout our one world virtually as these trends develop, and are increasingly interested in their social and individual implications.

Dr. Chisholm, as the first director general of the World Health Organization and president of the World Federation for Mental Health, has been in a strategic position to evaluate these tremendous changes, particularly those of the last few years, in terms of the requirements they impose on human beings for adapting if they are to survive and remain reasonably healthy. This fascinating group of four essays was delivered as the Bampton Lectures at Columbia University.

Dr. Chisholm suggests that many attitudes and institutions and much human behavior up to now considered normal have to be changed. He casts an eye knowingly over one culture and another, indicating rather than categorically stating how it is this seems to be so. Then he suggests some ways by which these changes may come to pass.

This little volume is heartily recommended to all readers interested in the subject of individual and social integration for

the challenge, the warning and the fresh ideas it presents.—OSCAR E. HUBBARD, M.D., University of Mississippi School of Medicine.

MENTAL HEALTH IN COLLEGE AND UNIVERSITY

By Dana L. Farnsworth, M.D.

Cambridge, Harvard University Press, 1957. 244 pp.

Educators everywhere are beginning to realize, in these critical times, that the chief problem confronting civilization is not the technical control of atomic energy, but the harnessing of man's energies, particularly his aggressive ones, to constructive uses. This concern appears to lie at the heart of Dr. Dana Farnsworth's informative and captivating new book. He speaks from his two decades of experience in student medicine and student psychology with considerable authority and urgency. And he speaks especially of the vital necessity for higher education to teach *by example*, as well as by precept, the value of applying the spirit of patient inquiry to everyday human relations—notably, to prejudices, misconceptions, antagonisms and misconduct of all kinds. For, although resistance remains formidable to the recognition of profound emotional elements in "normal" life, twentieth-century medical psychology has amply confirmed what Freud first pointed out in *The Interpretation of Dreams* and in *The Psychopathology of Everyday Life*—that powerful emotional undercurrents influence human behavior in health as well as in disease.

Dr. Farnsworth does not propose that teachers become psychiatrists or psychoanalysts, nor that the latter become teachers. But what he believes is that educational progress in particular and human welfare in general depend on achieving a juster and

better control over these submerged emotional elements, and that this can be better done by bringing them out into the light of day than by driving them underground, only to have them recur with renewed force.

It would be misleading to give the impression that Dr. Farnsworth's book is primarily concerned with these theoretical matters. On the contrary, it is especially valuable to the educator because of its eminently practical approach to student life and the learning process. It contains a wealth of material on the very real educational problems of today, often presented in historical perspective, as in the interesting chapter on student customs, morale and attitude. The chapter on counseling and psychotherapy gives an illuminating discussion of what there is in common between these two approaches and how they differ. The chapters on the administration and the psychiatrist and on emotions and the curriculum accent and illustrate how fundamentally alike are the aims of the educator and the psychiatrist, and how each can contribute more to the education of students by supplementing and enriching his own viewpoint with that of the other.

Psychiatry during the last few decades has given fresh support for an old idea about experience being the best teacher—namely, that optimal learning is closely connected with the interests and vital problems of actual daily life, and that these

in turn cannot be forced or arbitrarily imposed. As Earnest pointed out in *Academic Procession* (New York, Bobbs-Merrill Co., 1953), universities prior to the present century were largely given to forcing students to learn by rote material that seemed to them far removed from contemporary life. Today the coercive, inflexible and impersonal attitudes in the teachers of the past are seriously suspected of blocking rather than facilitating the learning process. Dr. Farnsworth remarks that they only seem to "perpetuate rebellion, negativism and hostility" on the part of students. Instead of complaining about the "immaturity" of students, or of relying on punishment alone to cure it, Dr. Farnsworth reminds us that: "Immaturity in all its forms—lack of knowledge, misconceptions, prejudice, sensitivity, tensions between individuals and groups, and unreasonable fears—is the reason for the existence of the teacher as a professional person." And it is also the reason for the psychiatrist's profession. He therefore proposes that teachers and student psychiatrists co-operate in bringing an attitude of personal interest and understanding to student viewpoints and difficulties as they present themselves—without, however, any sacrifice of the ideal that students and university should share together: namely, the search for excellence and for optimal achievement.—LOUIS E. REIK, M.D., Princeton University Department of Health.

Notes and Comments

NUMBER OF PATIENTS STILL GOING DOWN

A continuing decline is shown this year in the rolls of U. S. mental hospitals.

The decrease, progressive since 1956, indicates a definite favorable trend in treatment of mental illness. Prior to 1956, mental hospital rolls had increased steadily for 25 years.

Resident populations in state and county mental hospitals of 18 representative states decreased by 3,611 between June 1957 and June 1958. Projecting these figures to the entire United States gives an estimated total reduction of over 7,000, or about 1%. The reduction was somewhat less than that noted during the first year after the turning point in 1956 and slightly above that shown last year.

Hospital admissions, rising during the past three years, have been offset by even greater increases in hospital discharges, resulting in a net drop in hospital population. In 1955, 119,000 patients were discharged from public mental hospitals and in 1956 and 1957 comparable figures rose to 133,000 and 145,000.

The sharp increase in discharge of mental patients has created a new and acute problem, Judge Luther Alverson, president of the National Association for Mental Health, said recently. "Many recovered patients are returning to communities unprepared to receive them. There is still a great deal of unwarranted fear and hostility toward the returned patients, even among neighbors and family members. Employers, while expressing sympathetic interest, still resist hiring former patients. Facilities for out-patient follow-up medical care are practically non-existent.

"Many patients are unable to contend with these obstacles and break down and have to return to the hospital. Others are

forced into an unsatisfactory adjustment and become a burden to themselves, their families and their communities."

To meet this new problem, Judge Alverson said, NAMH is pressing for local programs of social, vocational and psychiatric rehabilitation and affiliates of the organization have given a #1 priority to these programs.

CARE AND TREATMENT

Emergency treatment around the clock for private and semi-private psychiatric patients is a feature of New York City's Gracie Square Hospital.

The 6-story air-conditioned structure, built at a cost of \$3,500,000, has a capacity of 232 beds. All recognized forms of treatment will be available. The hospital will maintain a day and night program for out-patients and a geriatric service for the aged. It will also accept patients addicted to opiates, barbiturates and alcohol.

The hospital's location—in crowded Manhattan—is in line with the current philosophy that the mentally ill should be treated in the heart of the community where relatives and referring doctors can easily visit.

• • •

The U. S. Internal Revenue Service has ruled that tax-deductible medical care includes the entire cost of institutional care for a person who is mentally ill and unsafe when left alone.

The test case involved a mentally retarded child whose doctor felt it was neither safe nor practical for him to remain with his parents or in an urban community. He was placed in a home with an opportunity of marginal adjustment.

• • •

A survey conducted by the Pima County, Ariz., Association for Mental Health shows

that more than 1,200 Tucson school-age children are in urgent need of special service because of social or emotional problems interfering with their progress in school.

• • •

Rhode Island has 1,678 children from 5 to 18 who are emotionally ill, according to a survey co-sponsored by the state mental health association. Top-priority goal of the association and other interested organizations is to fill the gap in child guidance clinic services. A goal of 8 out-patient clinic teams has been set. As in many other states, there is also great need for a residential psychiatric treatment center, especially for adolescents.

• • •

Another state hospital administrator has gone abroad to study England's famed open mental hospitals. He is Dr. Arthur L. Seale, superintendent of the Central Louisiana State Hospital at Pineville.

His investigation and study is being subsidized jointly by the Louisiana Association for Mental Health and the State Department of Hospitals.

He is visiting, among others, the Horton Road and Coney Hill hospitals in Gloucester. The unlocking of these particular institutions was described in fascinating detail in the January 1958 issue of *Mental Hygiene*.

• • •

Governor Averell Harriman drove the first pile October 17 for New York's first new mental hospital in 27 years.

Stressing in his speech the significance of environment in the treatment of mental patients, Governor Harriman said: "The doors of the beautiful new buildings to be constructed here will not clang shut like prison gates on the sick people who enter them for treatment. With increasing enlightenment, with the barriers crumbling between hospital and community, New York

State has emerged from the ancient shackles of superstitious fear which turned our mental hospitals into grim fortresses. We know now that environment is an essential part of treatment."

• • •

New York is not spending enough on mental health research, training and community psychiatric services, in the opinion of a committee of the State Society for Mental Health. The current \$1-per-capita rate of state aid for psychiatric services in general hospitals is both "inadequate and unrealistic," according to the State Citizens Advisory Group for Mental Hospitals and Schools.

In a report presented October 27 in Albany at the society's 2nd annual mental hospital institute, the advisory group recommended the creation of standing committees on mental hygiene in both houses of the state legislature, the development of small independent units within New York's huge public mental hospitals, and closer cooperation between the hospitals and local mental health boards.

The group also reported that:

- Education and training of personnel in mental institutions have been "woefully neglected."
- Institutional environments should be more cheerful and home-like.
- Operation of large farms by mental hospitals is "debatable and probably unsound."
- Further study should be given to the possibility of restoring mental patients' full legal rights rather than treating them as incompetent before the law.

• • •

On every hand these days is telling evidence that mental patients are breaking through the barriers that long isolated them from the rest of the community.

For example, five years ago not one general hospital in Kansas would take mental patients. Now 68 of the state's 167 licensed hospitals will accept them, for temporary care at least.

RESEARCH

Grants totaling \$124,200 for 26 continuing research projects on schizophrenia, stipends for the training of student researchers and operating costs have been announced.

The grants were made November 8-9 at a meeting of the schizophrenia research committee of the Supreme Council, 33rd Degree, Scottish Rite Freemasonry, Northern Masonic Jurisdiction. The research program is directed through the National Association for Mental Health, which was represented at the meeting by Dr. William Malamud, research director, and Dr. George S. Stevenson, national and international consultant.

With these grants for the 1959 research projects, a total of over \$1,460,000 has been contributed by the Scottish Rite for its major benevolence—research in the causes and treatment of schizophrenia. Sovereign Grand Commander George E. Bushnell of Detroit said funds contributed by Freemasons throughout the northern Masonic jurisdiction during December would go for the support of schizophrenia research.

The following grants were renewed:

Dr. Kenneth Appel, Institute of the Pennsylvania Hospital, Philadelphia. Effects of drugs on specific personality functions. \$5,000.

Dr. Philip Bard, Johns Hopkins University, Baltimore. Brain mechanisms involving aggressive behavior. \$2,000.

Dr. George H. Bishop, Washington University, St. Louis. Cortical activity in mammals. \$2,500.

Dr. Samuel Bogoch, Massachusetts Men-

tal Health Center, Boston. Studies of norepinephrine in schizophrenia. \$4,800.

Dr. C. H. Hardin Branch, University of Utah, Salt Lake City. Indole studies in schizophrenia. \$5,000.

Dr. Norman Q. Brill, University of California, Los Angeles. Assay of ACTH in the blood in relationship to schizophrenia. \$5,500.

Dr. P. H. Bulle, Georgetown University, Washington, D. C. Determination of the presence and effects of serotonin and related substances in the cerebrospinal fluid. \$5,000.

Prof. Erwin Chargaff, Columbia University College of Physicians and Surgeons, New York City. The chemistry of some metabolic processes of the brain. \$2,000.

Dr. Robert Allen Cleghorn, McGill University, Montreal. Neurohumoral and endocrine functions in schizophrenia. \$4,500.

Dr. Daniel H. Funkenstein, Boston Psychopathic Hospital. Psychological and biochemical studies of reactions to stress. \$4,000.

Dr. Francis J. Gerty and Dr. Leo Abood, University of Illinois Neuropsychiatric Institute, Chicago. The chemistry and effects of drugs that produce symptoms of mental diseases. \$3,500.

Dr. J. S. Gottlieb and Dr. Charles E. Frohman, Wayne University, Detroit. Studies of phosphorus metabolism in schizophrenics. \$5,000.

Dr. Hudson Hoagland, Worcester Foundation for Experimental Biology, Shrewsbury, Mass. Effects of some blood constituents of schizophrenics on animal behavior. \$5,000.

Dr. Franz J. Kallmann, New York State Psychiatric Institute, New York City. Genetic studies of preadolescent forms of schizophrenia. \$4,000.

Dr. Irving Kaufman, Judge Baker Guidance Center, Boston. Studies of the treat-

ment process of childhood schizophrenia. \$4,800.

Dr. Peter Knapp, Boston University School of Medicine. Methodological studies of affective reactions. \$4,000.

Miss Meta A. Neumann, St. Elizabeths Hospital, Washington, D. C. Histochemical studies of the basal ganglia. \$5,000.

Dr. Zygmunt A. Piotrowski, New Jersey Neuropsychiatric Institute, Princeton. Preceptanalytic studies of schizophrenia. \$3,000.

Dr. Marian Putnam and Dr. Beata Rank, James Jackson Putnam Children's Center, Roxbury, Mass. Analysis of treatment process of children manifesting "atypical" behavior. \$4,500.

Dr. Ralph D. Rabinovitch, Hawthorn Center, Northville, Mich. Indole studies in schizophrenic children. \$4,000.

Dr. Carl Schmidt, University of Pennsylvania School of Medicine, Philadelphia. Effects of drugs on the nervous system. \$3,000.

Dr. Harry Sobotka, Mount Sinai Hospital, New York City. Microbiologic assay of drugs used in mental illness. \$4,600.

Dr. Ian Stevenson, University of Virginia School of Medicine, Charlottesville. Clinical and physiological studies of the effects of drugs. \$6,000.

Dr. Heinrich Waelsch, New York State Psychiatric Institute, New York City. New aspects of amine metabolism. \$3,000.

Dr. Alfred Washburn and Dr. John Benjamin, Child Research Council, University of Colorado, Denver. Analytic studies of personality development. \$5,000.

Dr. John C. Whitehorn, Johns Hopkins University, Baltimore. Studies of the process and predictability of results of treatment of schizophrenics. \$5,000.

* * *

Researchers and clinicians from all parts of the country met in Washington October

27 to lay the groundwork for new research on the effects of tranquilizers and other drugs on children. The conference was called by the Psychopharmacology Service Center of the National Institute of Mental Health.

Clinical and laboratory psychologists, pediatricians, psychiatrists, social workers and neuropharmacologists combined their knowledge and experience to pinpoint the most crucial problems in the use of these drugs on children. They also recommended ways that the problems can best be attacked through research on normal children as well as on the emotionally disturbed or mentally ill or retarded.

The group discussed how drug effects can be accurately measured, how to determine whether drugs can safely be given to children for long periods of time, and the effect of drugs on learning ability and other aspects of a child's development.

* * *

A research center for the study of drugs and their use in the treatment of mental illness was officially opened November 20 at Saint Elizabeths Hospital in Washington, D. C. The project is operated jointly by the hospital and the National Institute of Mental Health.

The new Clinical Neuropharmacology Research Center is being equipped for a comprehensive, scientific assessment of the tranquilizing and energizing drugs and their effects on mental function, particularly in the treatment of mental disorder.

Dr. Joel J. Elkes, NIMH pharmacologist and former chairman of the department of experimental psychiatry at the University of Birmingham in England, is director of the center.

Dr. Robert H. Felix, NIMH director, said there has long been a need for a research center in a mental hospital to work

in conjunction with the clinical center in Bethesda, Md. He noted that Saint Elizabeths, one of the country's outstanding mental hospitals with a patient-population of 7,500 and located only a few miles from the clinical center, is ideal for such a collaborative program.

Dr. Winfred Overholser, superintendent of Saint Elizabeths, said the hospital has always welcomed promising innovations. "This program, I believe, holds particular promise not only for Saint Elizabeths but for psychiatry in general," Dr. Overholser commented. "I am confident that this carefully planned research undertaking will bring forth knowledge that will guide us in the use of drugs and from which new effective treatment methods will evolve," he said.

The building selected for the project houses 350 patients and provides opportunity for intensive clinical studies. Laboratories and other facilities for basic research are being installed.

Working together on the project will be psychiatrists, psychologists, pharmacologists, biochemists, physiologists and a variety of other research specialists. They are starting an extensive series of studies for determining exactly what happens, physically and psychologically, when drugs are used in the treatment of mental disorder in a hospital. This will include clinical studies with patients suffering from different types of mental illness and also basic research on the actions and reactions of the various drugs.

The program will also include studies designed to measure the changes in hospital management and care brought about by the use of the drugs and how such environmental changes affect the patient. The very fact that the drugs bring withdrawn patients out of their defensive retreat so that they can be reached by psychotherapy also makes

them more responsive to other influences in their environment, Dr. Elkes pointed out.

"The attitudes of hospital personnel, the physical arrangements for the patient's care, even the lay-out of the ward itself, enter into the therapeutic process and become more meaningful for good or ill," he said.

* * *

A 2-year study of mental depression has been undertaken by Rutgers University and the New Jersey Department of Institutions and Agencies. The National Institute of Mental Health is subsidizing the investigation with a grant of \$158,000.

The principal aim is to measure the effectiveness of two treatment methods for depressed mental patients. The methods are electro-convulsive therapy (shock treatment) and the use of iproniazid, an anti-depressant drug.

The causes of depressions will also be investigated.

Dr. V. Terrell Davis, state director of mental health and hospitals, said the study "represents the beginning of major collaborative research between the state university and the state hospital system." It will call on the professional skills of psychiatrists, psychologists, psychiatric social workers and nurses, biochemists and physiologists.

* * *

A 5-year study of the social and psychological stresses that arise when homes are razed and families relocated to make way for industrial expansion is getting under way in Boston's West End. It will be carried on by the Center for Community Studies with Dr. Erich Lindemann, Harvard University professor of psychiatry, as the principal investigator. It will be subsidized by the National Institute of Mental Health.

The research will include interviews with both husbands and wives in a random sample of 400 families. The study team will also interview small groups of selected people on special problems: family life, community life, adaptation to crises, and the meaning of the physical environment. Those interviewed will be questioned before moving and again several years later.

* * *

Significantly more mentally defective children are born during the winter than at any other time of year, a recent study shows.

A significant number of the mentally defective children born between 1913 and 1948 and now cared for at a state school in Columbus, Ohio, were born in January, February or March, two researchers—Dr. Hilda Knobloch and Dr. Benjamin Pasamann—have found. They conclude from this that mental defect is related in some way to the season of conception.

Writing in the September 1958 issue of the *American Journal of Public Health*, they point out that damage occurring during the third month after conception (when the cerebral cortex of the unborn child is becoming organized) could affect intellectual functioning.

"The months when this might happen would be June, July and August, the hot summer months when pregnant women might decrease their food intake, particularly protein, to dangerously low levels and consequently damage their developing babies," the authors note. "If this were so, one would expect that hotter summers would result in significantly more mental defectives born than following cooler summers.

"This was exactly what was found to a highly significant degree."

The authors conclude that inadequate dietary intake during pregnancy because of

heat or substandard economic conditions may be "an important link in the vicious cycle that results in poor physical and mental growth."

A similar article on season variation in the incidence of severely crippling mental disorders appeared in the October issue of the *American Journal of Psychiatry*. It was written by Dr. Nelson J. Bradley and Rubel J. Lucero.

They found that mental patients between 60 and 69 entered the hospital most frequently in November and least frequently in April. No other age group varied from month to month.

Psychoneurotics, they found, entered the hospital most frequently in June, July and October, least frequently in December, January and February. Those who were married varied the most.

The authors based their observations on a 3-year study of 976 consecutive admissions to the Willmar State Hospital in Minnesota, and emphasize that their findings apply only to patients in rural areas.

* * *

The Hofheimer Prize of \$1,500 is awarded annually by the American Psychiatric Association for an outstanding research contribution in the field of psychiatry or mental hygiene which has been published within a 3-year period up to the date of the award. Studies in press or in preparation are not eligible.

This competition is open to citizens of the United States and Canada who are 40 years of age or under at the time the study was submitted for publication or to a research group whose median age does not exceed 40.

The next award will be made at the annual meeting of the APA in April 1959. Entries submitted to the prize board before February 15, 1959 will be considered. Eight

reprints or duplicated copies of each entry as well as the necessary data concerning age and citizenship should be sent to Dr. John I. Nurnberger, chairman, Hofheimer Prize Board, 1100 West Michigan St., Indianapolis 7, Ind. All entries are independently evaluated by each member of the Hofheimer Prize committee and final selection is determined by equal vote.

TRAINING

The training of mental health specialists has improved both in quantity and quality during the last decade, in the opinion of the National Institute of Mental Health.

In a comprehensive report to Congress on the institute's training program at the end of its first 10 years, NIMH lists 10 methods used to expand the nation's mental health resources:

- Pilot projects to develop ways of training specialists for work in key mental health problem areas.
- Grants to enable promising psychiatrists and scientists to devote themselves to careers in mental health research.
- Grants to enable qualified individuals to make a career of mental health teaching.
- Psychiatric teaching for undergraduate nursing students.
- Training of specialists for community mental health activities.
- Senior stipends for advanced mental health training of established teachers, researchers and administrators.
- Part-time stipends for medical students wanting experience in psychiatric clinics and research laboratories.
- Training programs in mental health research for personnel in the basic and applied sciences.
- Training programs for epidemiologists and biometricians for medical research, post-sophomore research fellowships for medical students and postdoctoral fellowships for outstanding foreign scientists.
- Grants to train social workers and psychologists for vitally needed mental health work in the schools.

In the decade between July 1, 1948 and June 30, 1957 NIMH spent \$33,650,156 on its mental health training programs.

This year NIMH expects to launch a new series of grants designed to increase the supply of research psychologists.

Looking ahead, the report forecasts a heavy emphasis for the next five years on the establishment of basic science departments of human behavior in medical schools. Also needed, NIMH says, is improved research training for university students early in their professional or pre-professional education. Another step, Congress was told, is the training of personnel for preventive mental health services and for treatment and research work in geriatrics, alcoholism, juvenile delinquency and mental retardation.

* * *

Dr. Cyril J. Ruilmann, Texas' recently appointed director of mental health and hospitals, has been elected chairman of the Southern Regional Council on Mental Health Training and Research for 1958-59. The council, composed of representatives of the governors of 16 southern states and other specialists in mental health professions, serves as an advisory body to the Southern Regional Education Board.

* * *

In a direct attack on some of the training and research problems in the field of mental retardation, the Southern Regional Educa-

tion Board has formed a panel to advise and assist the board in:

- Assessing the research and the professional and technical training needs in this field.
- Identifying promising practices in meeting these needs.
- Formulating various solutions to problems blocking the meeting of needs.
- Stimulating the implementation of recommended solutions.

The board is also sponsoring a series of conferences that bring together five or six research workers engaged in similar studies to discuss their common interests and problems. One 2-day conference focused on the problem of measuring and analyzing abnormal activity in mentally retarded and disturbed children. Another centered on studies of the brain stem in relation to learned and unlearned behavior. The next scheduled conferences will be on biochemical research with mongoloid children and on experimental studies of the learning process in retardates.

• • •

Meeting in special session November 6-7 in New York, the board of the National League for Nursing approved measures to improve the education of psychiatric aides. The organization will stimulate experimental pre-service education programs for aides, help set up educational standards, and prepare curriculum materials.

The board also reaffirmed an earlier statement that "psychiatric aides who give care to the mentally ill are practitioners of nursing," approved an earlier recommendation that NLN assume leadership and responsibility in the training of aides as well as other nursing personnel caring for psychiatric patients, and reiterated its intention of

fostering and improving on-the-job education of aides.

• • •

A total of 33 grants for in-service training of workers in mental institutions of southern states have been awarded to date by the Southern Regional Education Board under its program in mental health training and research. Five more applications are being processed.

Nineteen mental hospital employees and 14 employees in training schools have received an average of \$202 to visit facilities for the care and treatment of the mentally ill or retarded in 10 different states.

More than half of the grants have gone to personnel in Virginia and Louisiana. The remaining grants were awarded in Kentucky, South Carolina, North Carolina, Maryland, West Virginia, Oklahoma and Texas.

These in-service training grants were made possible by a \$90,000 grant by the National Institute of Mental Health. They are designed to enable staff members of mental hospitals or training schools in the South to observe new or unusual programs in other hospitals anywhere in the country.

Visits averaging 9 days were made to a variety of institutions including the geriatrics unit and research unit of a mental hospital, an open door hospital and a facility for emotionally disturbed children. Grantees observed programs ranging from food service management to teaching music to retarded children.

All but six of the visits were made to states outside the South. Seven grant recipients went to Connecticut, 10 to New York, 3 to Michigan and Ohio, 2 to Illinois, Florida and Washington, D. C., and one to Virginia, California, Maryland, Massachusetts and Kansas.

Reaction of the grantees has been very favorable, the SREB reports. Grants have

been awarded teachers, hospital superintendents, psychiatric social workers, attendants, nurses, librarians, psychologists, physicians and directors of research, volunteer programs, recreation, education and food service.

The 2-year grant from NIMH permits the SREB to award approximately 100 grants each year. Grants up to \$500 to cover travel and maintenance are made for 1- and 4-week visits. Applications are still being accepted by SREB. Those interested should write directly to the Southern Regional Education Board, 881 Peachtree St., N.E., Atlanta 9.

* * *

A new performance test for psychiatric aides is being distributed by the National League for Nursing.

It includes a test in elementary psychiatric nursing and a second one in basic nursing procedures and elementary nutrition. Norms for the tests are based on the performance of more than 4,000 psychiatric aides and attendants who had been employed in 63 mental hospitals for at least a year. This test service is available to hospitals which employ psychiatric aides and attendants, and mark NLN's first venture in the construction of a test for employed personnel.

Cost of the test service is 75¢ a person tested with the elementary psychiatric nursing test, and \$1 a person tested with the basic nursing procedures and elementary nutrition test. The latter provides a score in each of the two areas tested, plus a total score.

Further information about the test may be obtained from the National League for Nursing, 2 Park Ave., New York 16.

* * *

Through a grant from the Public Health Service, a number of National Institute

of Mental Health traineeships have been made available to men and women interested in advanced study in the doctoral program in social work and social science offered at the University of Michigan. Applicants for the program may be considered also for fellowships provided under a grant from the Russell Sage Foundation. Fellowship stipends range from \$600 to \$3,600, including dependency allowances.

The interdepartmental program offers degrees combining social work with either sociology, social psychology, psychology or economics, and prepares students for careers in research, teaching and policy development. Students with bachelor's degrees only, as well as those with a master's degree in social work or a social science discipline, may apply for admission to the interdepartmental program.

Fellowship applications will be received up to February 1, 1959. Applications for admission may be filed up to June 1, 1959. For detailed information and application forms, write to Dr. Henry Meyer, School of Social Work, University of Michigan.

* * *

Medical schools are being encouraged to apply to the National Institute of Mental Health for grants with which to finance psychiatric training of family doctors. Of \$1,300,000 appropriated by the 85th Congress for this purpose, \$800,000 is available to the schools as stipends for physicians who have been practicing at least four years and who wish to take standard psychiatric residency training.

The other \$500,000 will be available to the medical schools (and to psychiatric departments of hospitals and psychiatric societies) to pay instructors of postgraduate courses in psychiatry for general practitioners.

Dr. Charles E. Goshen, director of the

American Psychiatric Association's general practitioner education project, is prepared to aid in formulating, evaluating and publicizing training programs, obtaining psychiatric lecturers, establishing liaison with other medical groups, and applying for grants.

* * *

A marked increase in grants for the training of more mental health personnel was reported this fall by Dr. Robert H. Felix, director of the National Institute of Mental Health.

Grants to date in this fiscal year total more than \$16,000,000, compared to about \$13,000,000 last year. They are financing the training of new psychiatrists, psychologists, psychiatric social workers, psychiatric and public health nurses.

PUBLIC INFORMATION

Increased public awareness of mental illness as New Jersey's leading health problem is noted in the latest annual report of the state mental health association.

Dr. Edward P. Duffy, Jr., president, said this growing concern had been observed by his association and its 14 county chapters in six different advances:

- The rapid growth of mental health clinics and child guidance centers. Under New Jersey's Community Mental Health Services Act of June 1957, which the mental health associations vigorously supported, 19 of the state's 21 counties have taken first steps toward the organization of clinics. This past year mental health volunteers directly helped to launch three clinics in Gloucester, Morris and Middlesex counties.

- Increased requests for information and help in finding care and treatment for emotionally or mentally ill residents.

- Increased requests for publications, exhibits, films, plays and speakers on mental health.

- Increased attendance at special seminars on mental health for teachers, clergymen, police officers, nurses and industrial leaders.

- Significant legislative gains, including larger appropriations for the care of hospitalized mental patients and the creation of a state mental health research program.

- A 33% increase in public contributions to the 1957 Mental Health Campaign.

* * *

A former mental patient's fight against the fears and prejudices of his fellow workers is dramatized in poignant detail in a new Mental Health Film Board release called "Bitter Welcome."

It shows, with humor and suspense, how he battles to keep his job, his home and his self-confidence in the face of deep suspicion and outright antagonism. So far as is known this is the first film depicting the rehabilitation problems of the recovered mental patient.

Praising the film as an educational tool, the education committee of the National Association for Mental Health has recommended that all mental health associations incorporate "Bitter Welcome" in their public and professional education programs. Showings should be arranged, the committee believes, not only for the general public but for specialized groups such as doctors, nurses and the relatives of those hospitalized because of mental ills.

Prints of the 36-minute film are available (\$145 purchase, \$8.50 rental) from the NAMH Film Library, 267 W. 25th St., New York 1.

Notes and Comments

Employment of rehabilitated former mental patients is the theme of a billboard design contest to be conducted next year among New Jersey's high school students. The contest will be conducted by the Governor's Committee to Employ the Handicapped. The New Jersey Association for Mental Health has contributed \$300 toward prizes.

APPOINTMENT

Dr. Harvey J. Tompkins, 1st vice-president of the National Association for Mental Health and chairman of its professional advisory committee, has been named chairman of New York City's Community Mental Health Board. He will serve in the unsalaried post until December 31, 1961.

Dr. Tompkins, who is director of the psychiatric division of St. Vincent's Hospital, New York City, is also clinical professor of psychiatry at New York Hospital, a member of various local, state and national mental health committees and coordinator of psychiatric activities for Catholic charities of the Archdiocese of New York.

MEETINGS

Climaxing its 50th anniversary celebration, the Connecticut Association for Mental Health sponsored a state-wide institute on the returning mental patient. It was held November 7 in Hartford with Miss Mary Switzer, director of the U. S. Office of Vocational Rehabilitation, as the main speaker.

In three sociodramas psychiatrists in training at Yale University School of Medicine demonstrated various problems faced by the former mental patient. Representatives of the clergy, industry, labor, nursing, social service and the Veterans Administration discussed the community's ways of helping the patient handle his troubles.

Such topics as the employment, after-

care and social readjustment of discharged patients were also gone into in workshops.

* * *

For the first time in history, so far as is known, the men who direct state mental health and mental hospital programs sat down together this fall to talk over their common administrative and fiscal problems. They liked the experience so much they decided to organize as a permanent group and meet regularly as the Council of Mental Health Commissioners.

Many reported better patient-staff ratios in mental hospitals, decreasing hospital populations despite the highest admission rates in history, and the greatest number of discharges ever recorded.

Twenty-nine states were represented at the meeting, held in Kansas City under the auspices of the American Psychiatric Association. An executive committee formed to work out the details of organization includes Dr. George Jackson of Topeka; Dr. Clifton Perkins, Baltimore; Dr. Harold McPheeters, Louisville; Dr. Hayden Donahue, Oklahoma City; Dr. Granville Jones, Little Rock; Dr. Addison Duval, Jefferson City, Mo.; Dr. Cyril Ruilmann, Austin, Texas; Dr. John Davis, Harrisburg, Pa.; Dr. Earl Holt, Concord, N. H., and Dr. John B. K. Smith, Juneau, Alaska.

* * *

The American Psychiatric Association dedicated its new headquarters building at 1700 18th St., N.W., in Washington this fall.

Secretary of Health, Education and Welfare Arthur S. Flemming gave the dedicatory address October 31 in ceremonies attended by 200 APA leaders and officials from other professional organizations.

APA's top officers include Dr. Francis J. Gerty of Chicago, president, and Dr. William Malamud, New York City, president-

elect. Other officers include Dr. William B. Terhune, New Canaan, Conn., Dr. David C. Wilson, Charlottesville; Dr. C. H. Hardin Branch, Salt Lake City, and Dr. Robert H. Felix, Bethesda, Md.

APA, oldest national medical association in the U. S., was founded in 1844 by 13 physicians as the Association of Medical Superintendents of American Institutions for the Insane. In 1892 the name was changed to the American Medico-Psychological Association and in 1921 to the present title.

Over the years the membership has grown from the original 13 to 10,000. The shortage of psychiatrists in this country is still acute, however, and it is roughly estimated that at least double the present number are needed to take care of the nation's mentally ill.

• • •

A national committee on mental health has been created within the National Association of County Officials for the purpose of working with mental health associations throughout the country.

A formal resolution calling for cooperation with the National Association for Mental Health and its affiliates was passed by county government leaders at their annual conference August 10-13 in Portland, Ore. It authorizes the formation of a national committee to "cooperate state-wide and nation-wide with accredited mental health associations in preventive programs relative to the difficult but essential task of providing more care, protection and aid for the mentally ill."

The resolution was presented to the NACO convention by Commissioner John Poda of Summit County, Ohio.

• • •

There has been a boom in the mental

health movement, and it shows no signs of letting up.

This was a primary point of agreement among 53 leading educators and other professional workers who participated in a National Assembly on Mental Health Education held September 10-13 at Cornell University. They gathered to analyze current views on mental health education, chart its future course, and point to topics requiring research.

The assembly, initiated by Pennsylvania Mental Health, Inc., was co-sponsored by the National Association for Mental Health and the American Psychiatric Association. It was subsidized by a grant from NAMH.

"We are not suffering from lack of mental health education," Dr. Erich Lindemann pointed out in the only formal paper of the conference.

"Mental health is the topic of the day in most journals, on radio and television. Legislatures and Congress find it necessary to give increasing amounts of money to research, service and training in psychiatry, psychology and social work, and are now including demonstrations in such training for general practitioners, clergymen and law enforcement people."

Dr. Lindemann is professor of psychiatry at Harvard Medical School and psychiatrist-in-chief at Massachusetts General Hospital.

In the two and a half days of discussions that followed his talk, most conference participants conceded the need for this upsurge of activity on behalf of those who are mentally ill or might become so.

They agreed also that all professional workers—doctors, clergymen, lawyers, judges, teachers and others—are involved in mental health education. Each draws from the common well of available knowledge about what constitutes mental health, and each adapts this scientific information, in the

light of his own professional orientation, for the particular group he serves.

Members of the assembly spent a great deal of time on the matter of promoting positive mental health. All recognized the lack of unanimity about the content of the field, the uncertainty about educational techniques and their effectiveness. And despite these doubts, all recognized a strong desire among professional workers and public for more and better mental health education geared to helping people live more satisfying lives.

As viewed through the eyes of three NAMH staff members who participated—Dr. George S. Stevenson, Edward Linzer and Harry Milt—the conference at Ithaca erected a number of important signposts for mental health associations. For example, in considering the goals of mental health education one discussant pointed out that mental illness is a reality that must be dealt with. Another added that any soundly conceived program aimed at improving the lot of the mental patient and his family is bound to be effective in promoting sound principles of mental health. Conversely, educational programs designed to advance mental health should simultaneously lead toward improved care and treatment of the mentally ill.

In the view of another, mental health education had these four goals:

- The reduction of stigma and accompanying fear in our approach to all the problems connected with mental illness.
- The gathering and disseminating of accurate information on mental disorders.
- The dissemination of information on personality development.
- The stressing of steps people may use in helping themselves.

Whatever the goal of a specific program, however, many discussants felt it the mental

health association's duty to know the full range of mental health educational activities going on in the community, to examine them all in the light of the community's over-all needs, and to guide their development and expansion.

All in all, the conferees paid a good deal of attention to educational techniques.

Though some were inclined to minimize the role of the mass media in mental health education, by the end of the assembly most participants seemed ready to agree that in the last few years magazines, TV, radio and newspapers had helped to bring the subject of mental illness into the open. They noted that people seem more willing to discuss mental disorders than they used to, and are quicker to seek treatment for themselves or their relatives.

(The CBS film "Out of Darkness" was cited as an outstanding attempt to help very large numbers of people—perhaps 20,000,000—to a realization of what a psychiatrist is and what he does in psychotherapy.)

Hospital visiting was also examined as an educational technique. Some participants believed mass visiting helped to destroy the public's false stereotype of the mental patient and to create in its place a sympathetic understanding of the patient as a sick person in need of help. Others held that the best learning came not from a quick tour of the hospital but from serving there as a volunteer.

Those on the staff of a mental hospital would do well to devote time to educational activities in the community, one discussant observed. They could talk before community groups, serve as consultants to various health and welfare agencies, and participate in the professional life of the local college or university, it was said.

In addition to these well-recognized methods of education, the assembly pointed

to others, somewhat more indirect, with considerable potential: the formulation and promotion of legislation, the conducting of self-surveys, the personal involvement of thousands of volunteers.

It was generally agreed that it is pretty hard to measure the effectiveness of many of these techniques. Some take a long time to show results. Some are not reaching the right people.

Said one discussant: "The mental health movement must let its nets down deeper into the social structure to reach the depressed or submerged tenth of the population living in slums. Here are the unskilled workers, the unemployed and the migrants. The educational level is 7th grade or less.

"These people are not reached by family doctor, minister, society or union. The school teacher is the only one who constantly reaches the children on a day-to-day basis, and even her relationship is tenuous.

"A recent study indicated that twice as many people in disorganized areas had symptoms of mental illness as those in better organized areas, and they were more incapacitating. The uncertainty is how to reach them."

It was also generally agreed that wide-ranging research is a prime imperative in the mental health field. Among dozens of topics suggested for study were these:

- The content of various mental health education programs.
- The timing and appropriateness of various techniques.
- The effectiveness of educational methods in reaching the professions: doctors, lawyers, ministers and others.
- Public attitudes toward mental illness and techniques of changing them.
- The qualifications of mental health educators, lay and professional.

All sessions of the assembly were recorded and a comprehensive report of the discussions will be distributed this year. It will serve as the basis for an institute, under NAMH auspices, for key personnel of state and local mental health associations.

Those participating were Michael Amrine, science writer; Dr. Carl A. L. Binger, former president of the Mental Health Film Board; Don Belcher, of Smith, Kline & French Laboratories; Dr. Daniel Blain, Western Interstate Commission for Higher Education; Mrs. Helvi Boothe, formerly of the Menninger Foundation; Dr. Francis J. Braceland, physician-in-chief at the Institute of Living in Hartford, Conn.; Dr. Orville Brim, Jr., Russell Sage Foundation; Dr. John A. Clausen, National Institute of Mental Health; Dr. Jules V. Coleman, Dr. Ira Hiscock and Dr. A. B. Hollingshead, Yale University; Dr. Stuart W. Cook and Dr. M. Brewster Smith, New York University; Donald A. Crawford, Philadelphia management consultant; Dr. Elaine Cumming, University of Chicago; the Rev. Charles A. Curran, Loyola University; Albert Deutsch, author of *The Mentally Ill in America*; Dr. C. Douglas Darling and Dr. Dorothea Leighton, Cornell University; Dr. Henrietta Hewitt, Maryland Department of Mental Hygiene; Dr. Erik Erikson, Austen Riggs Center.

Others were Dr. Dana L. Farnsworth and Dr. Erich Lindemann, Harvard University; Charles H. Frazier, president, and Max Silverstein, executive director of Pennsylvania Mental Health, Inc.; Dr. Milton Freedman, executive director of the Mental Health Association of St. Louis; the Rev. C. Leslie Glenn, University of Michigan; Dr. John D. M. Griffin, general director of the Canadian Mental Health Association; Dr. Samuel Grob, associate director of the Massachusetts Association for Mental Health; Stockton Helffrich, National Broadcasting Company;

Miss Margaret Hickey, public affairs editor of the *Ladies' Home Journal*; Dr. John P. Horlacher, University of Pennsylvania; Rabbi Fred Hollander, Yeshiva University; Dr. Henry P. Laughlin, George Washington University; Edward Linzer, Harry Milt and Dr. George S. Stevenson, NAMH; Dr. Ralph H. Ojemann, Iowa Child Research Station; Dr. Harvey J. Tompkins, St. Vincent's Hospital, New York City; Dr. Ernest Osborne and Dr. Leo Rosten, Columbia University.

Others were Dr. Paul T. Rankin, assistant superintendent of the Detroit schools; Dr. Matthew Ross and Robert L. Robinson, APA; Dr. Howard P. Rome, Mayo Clinic; Dr. John A. Rose, Philadelphia Child Guidance Clinic; Elizabeth Ross, formerly deputy chief of the U. S. Children's Bureau; Dr. Loyd Rowland, executive director of the Louisiana Association for Mental Health; Dr. Fillmore Sanford, University of Texas; Dr. Kerry Smith, Association for Higher Education; Dr. Eliseo Vivas, Northwestern University; Dr. William Foote Whyte, New York State School of Industrial and Labor Relations, and Greer Williams, Joint Commission on Mental Illness and Health.

• • •

The White House Conference on Aging set for January 1961 is expected to have considerable influence on medical and other programs for the nation's "senior citizens." The conference, authorized by the last Congress, is to be under the over-all direction of a national advisory committee composed of outstanding citizens and recognized leaders in gerontology, economics, education, health, housing, recreation, religion and welfare.

Funds have been provided to help the states hold state conferences on aging in advance of the Washington meeting. These state conferences, likewise, are to be preceded by community meetings involving in-

dividuals, groups and organizations concerned with aging.

• • •

Staff members of mental hospitals, psychiatric services of general hospitals and schools for the mentally deficient, as well as mental health authorities of the U. S. and Canada, met in Kansas City October 20-23 for the 10th Mental Hospital Institute. They exchanged information on 18 topics bearing on the care, treatment and rehabilitation of mental patients.

The institute has been sponsored each year since 1949 by the American Psychiatric Association's mental hospital service.

• • •

Recruitment of more volunteers, particularly men and women with backgrounds in psychiatry and allied professions, was proposed last month as one way of easing the manpower shortage in the mental health field.

The recommendation was made November 10 by Richard P. Swigart, executive director of the National Association for Mental Health, at a national conference on the present status and future needs of mental hospitals. The conference, held in Washington, was called by Arthur S. Flemming, secretary of the U. S. Department of Health, Education and Welfare, and participated in jointly by Dr. Winfred Overholser, director of St. Elizabeths Hospital, only federally supported civilian psychiatric hospital in the country, and Dr. Robert H. Felix, director of the National Institute of Mental Health.

Mr. Swigart told the conference, attended by heads of 50 professional organizations, that he was convinced many of the thousands of volunteers who devote time and effort each spring to the Mental Health Campaign could with equal devotion pro-

vide more direct service to the mentally ill through their mental health associations. He pointed out that if funds are forthcoming NAMH is prepared to demonstrate, in a series of pilot projects in various cities, the wide variety of ways volunteers can supplement the professional care and aid needed by both hospitalized and homecoming mental patients.

Mr. Swigart also reported on the national conference on volunteer services to the psychiatric patient sponsored in Chicago last June by NAMH, the American Psychiatric Association, American Red Cross, Veterans Administration and American Hospital Association. It was attended by selected state mental health officials and volunteers representing major community groups serving the mentally ill.

Besides the serious personnel shortage, those attending the Washington meeting discussed three other topics of broad significance:

- The lack of adequate facilities and funds for the training of more mental health manpower.
- The need for improved communications between the federal Department of Health, Education and Welfare and the state and local mental health authorities.
- The importance of basic sociological research—on aging, for example—which sheds light on ways of preventing mental illness.

Morris Klapper, NAMH assistant executive director, represented the association and its affiliates November 3 at a similar federal conference on vocational rehabilitation. It too was called by Secretary Fleming and was arranged by Miss Mary Switzer, director of the U. S. Office of Vocational Rehabilitation.

Calling attention to mental health associations' deep concern with the employ-

ment problems of psychiatric patients, Mr. Klapper said NAMH proposes to spend a major effort in this direction for a long time to come. He pointed out that almost no state mental hospitals provide vocational guidance, job training or sheltered workshops for patients preparing to return to the community. And he noted that of 75 rehabilitation centers in this country which responded to a questionnaire, only a third reported they are satisfactorily serving ex-mental patients—though many thousands need help in finding jobs, homes and friends.

• • •

A relatively unexplored concept—the communicability of mental and emotional illness—came in for discussion November 21 at the 5th annual conference of mental health representatives of state medical associations, held in Chicago.

Chairman of the discussion was Dr. Walter Baer of Peoria, a member of the American Medical Association's council on mental health, which sponsored the 2-day meeting. Other round-table groups considered mental illness and health in the aged, education for psychiatric medicine, the Joint Commission on Mental Illness and Health, and mental retardation in school children.

Dr. Leo H. Bartemeier of Baltimore, council chairman, presided at plenary sessions. Guest speakers included AMA president Gunnar Gundersen and Dr. Jonas E. Salk.

• • •

A comprehensive program designed to aid the mentally retarded was recommended November 20-21 in New York at a meeting of the Council of State Governments. Sixty-five experts in health, education and welfare, including legislators from 30 states,

discussed ways of coping with mental retardation.

They urged especially that the retarded be enabled to enter institutions voluntarily, and criticized the stigma associated with court commitments.

They called for the establishment of diagnostic facilities in the community so that the retarded needing residential care could bypass the court and go directly from the diagnostic center to a school or hospital. They also urged careful study to determine whether an individual needed special classes or training, and called for permissive legislation making classes mandatory for those found educable.

Figures released at the conference put the number of severely mentally retarded at 1,600,000. An additional 3,200,000 are considered less severely retarded but seriously handicapped. More than 120,000 now receive institutional care.

The conference was organized by Sidney Spector, director of the council's Interstate Clearing House on Mental Health. The council, a research and advisory group created by the state legislatures and governors, serves as a secretariat to the Governors' Conference.

* * *

More than 4,000 specialists in human behavior, including psychiatrists, psychologists, social workers and educators, are expected to attend the 3-day 36th annual meeting of the American Orthopsychiatric Association at the Sheraton Palace Hotel, San Francisco, beginning March 30, 1959.

This will be the first West Coast meeting of the AOA, which brings together the key disciplines involved in the team approach to prevention and treatment of behavior problems and related training and research.

A presidential session on the evening of

March 30 will include addresses by Dr. Linus Pauling, Nobel laureate in chemistry and professor of chemistry at the California Institute of Technology, and Dr. Weston LaBarre, author and associate professor of sociology and anthropology at Duke University. The presidential address will be delivered by Dr. Stanislaus Szurek, professor of psychiatry at the University of California Medical School and director of children's services at the Langley Porter Neuropsychiatric Institute in San Francisco.

A wide variety of topics will be covered in about 60 scientific papers and 40 workshop sessions, with emphasis on social and cultural aspects of mental health, treatment methods and research.

An all-day symposium is planned on brain and behavior, with the morning discussion centering on neuropsychiatry and neurochemistry and the afternoon on psychodynamic and social factors in brain damage.

Arrangements are being made for attendance by non-members, according to Dr. Marion F. Langer, executive secretary.

Among topics scheduled for discussion are research in maternal-child relationships, a study of high school histories of persons who later became schizophrenic and various aspects of schizophrenia in children and adults, sociocultural factors in mental health and illness, religious patterns as related to behavior, treatment of fathers of problem children, mental health programming in schools, mental health rehabilitation programs, therapy for children with school problems, therapy for economically deprived children with emotional disturbances, mental health aspects of prenatal health and prematurity, disorders in learning, problems of adolescence and juvenile delinquency.

Also evaluation of mental health programs and results of therapy, residential treatment programs, studies on hemophilia

and anorexia nervosa, drug therapy experiments with children and day care programs for severely disturbed children. Four sessions are planned to include mental health films and their discussion.

Exhibits of organizations and of materials related to the practice of orthopsychiatry will be on display during the sessions.

Further information is available from Dr. Langer, American Orthopsychiatric Association, 1790 Broadway, New York 19, or from the chairman of the San Francisco arrangements committee, Dr. Donald A. Shaskan, Veterans Administration, 49 Fourth St., San Francisco 3.

* * *

The National Organization of the Institutes of Group Psychotherapy and Psychodrama will hold a 2-day session January 31 and February 1 in Detroit. For further information, contact Henry Feinberg, chairman of the program committee, 163 Madison St., Detroit 26.

* * *

The American Society of Group Psychotherapy and Psychodrama will hold its next annual meeting April 25-26 in New York City. Papers should be sent to Hannah B. Weiner, 1323 Avenue N, Brooklyn 30, program chairman.

* * *

The American Group Psychotherapy Association will hold its 3rd annual institute January 21-22 and its 16th annual conference January 23-24 in New York City. For further information, write to Dr. Cornelius Beukenkamp, public relations chairman, 993 Park Ave., New York 28.

* * *

The 5th annual western regional meeting of the American Group Psychotherapy Association will be held April 2-3, 1959 in

San Francisco, with more than 500 psychiatrists, psychologists, social workers, educators and others in allied fields expected to attend.

Advances the past year in group psychotherapy will be keynoted in a paper by Dr. Martin Grothjahn of Beverly Hills, with S. R. Slavson of New York City as discussant. Mr. Slavson is credited with being the father of group therapy in the U. S. and the author of several books on group therapy. He is also editor of the *International Group Psychotherapy Journal*.

More than 17 symposia, workshops and general sessions will discuss such subjects as group counseling in a state prison, group therapy programs for family agencies, group psychotherapy for criminal offenders, family group therapy, therapeutic techniques in adolescents' groups, the recently developed transactional analysis, treatment of psychotic patients by group methods, and allied subjects.

Information on the AGPA can be obtained from Dr. Donald A. Shaskan, western representative, at the VA Mental Hygiene Clinic, 49 Fourth St., San Francisco 3.

* * *

The largest delegations in the 8-year history of the National Association for Mental Health met in Kansas City in November for four days of workshops, business sessions and addresses by eminent speakers.

Coming at a time of increasing public insistence on adequate care, treatment and rehabilitation for the mentally ill, the 8th annual meeting and Mental Health Assembly attracted nation-wide attention to the importance of voluntary as well as public services for mental patients and their families.

Dr. Harvey J. Tompkins, 1st vice-president of NAMH and chairman of its pro-

professional advisory committee, formally opened the assembly Wednesday, November 19, with a report on latest developments in mental health and new concepts in aiding the mentally ill and their families. Dr. Tompkins was inducted November 10 as chairman of New York City's Community Mental Health Board.

Another feature of the keynote session was the introduction to the delegates of Dr. William Malamud, recently appointed director of NAMH research. Describing research as a key tool in the attack on mental illness, he said the new NAMH program would expand rapidly as more and more funds are allocated for laboratory work on the cause, control and prevention of mental disorders.

Following Dr. Malamud's address, Dr. John P. Horlacher of Philadelphia presented a formal report on the national conference on mental health education held last fall under the joint auspices of NAMH and the American Psychiatric Association. Dr. Horlacher, who served as chairman of the education conference, is a leading volunteer in Pennsylvania Mental Health, Inc., NAMH affiliate.

Miss Vivian Acord, public information representative for the Illinois Department of Public Welfare, was the principal speaker at a "get acquainted" luncheon following the opening plenary session. A former mental patient, she spoke feelingly of the value of day-in, day-out volunteer services, along with good public services, for the mentally ill.

In a dramatic ceremony during the luncheon the roll call of the states was conducted by the five regional NAMH vice-presidents: Augustus G. Means of Boston, G. Werber Bryan, Sumter, S. C., William W. Allis, Milwaukee, Mrs. Ernest R. Rector, Tulsa, and Irving Enna, Portland, Ore. The roll call was climaxed by the unveiling of the

1959 Mental Health Week billboard poster, showing the affectionate welcome given by a little girl to her father home from a mental hospital.

State mental health associations in Alabama, Louisiana, Ohio and Virginia were cited for achieving full status as divisions of NAMH this year, and the Maine association was honored as the newest provisional affiliate.

Still another high spot of the 4-day meeting was the banquet Thursday night with Adlai E. Stevenson delivering the major address. Speaking on "Our Mental Health Responsibilities in a Growing Democracy" he commented warmly on the growth of NAMH and its influence since he addressed the association's first annual meeting in Chicago in 1951.

Among the 700 guests attending the banquet were former President Harry S. Truman and Mrs. Truman.

In workshops Wednesday afternoon, all day Thursday and Friday morning participants discussed the variety of services provided by mental health associations to hospitalized and homecoming mental patients and their families. Film screenings and conferences on mental health education, community organization, fund-raising, public relations and volunteer services completed the work program.

Delegates transacted association business at sessions November 18 and 20, and members of the national board met November 18 and 21. NAMH president Luther Alverson of Atlanta presided at all sessions.

Social events, in addition to the Thursday banquet, included buffet dinners Tuesday for delegates from the five regions and a reception Wednesday night given by the Kansas City Association for Mental Health and the Kansas and Missouri state associations.

The assembly closed Friday noon with

a rousing "Ring the Bell for Mental Health" luncheon heralding the 1959 drive for funds. In a challenging speech Frank F. Elliott of Chicago, national campaign chairman, called on state and local mental health associations to double or triple their income next year, so as to be in position to meet the growing public demand for voluntary services to thousands of mental patients.

Citations and gifts—small gold charms in the shape of a bell—were presented to Virginia Graham and Margaret Whiting, co-chairmen of the annual Bell Ringers' March for Mental Health. Miss Whiting, unable to be present, sent greetings.

A special citation was also presented to the Connecticut Association for Mental Health for pioneering in the use of various fund-raising techniques, including the tel-ethon and radiothon. Individuals honored were C. Marvin Curtis, Connecticut's campaign chairman; Sidney Burns, in charge of special events, and Louis Kaplan, staff assistant.

* * *

The American Psychosomatic Society will hold its 16th annual meeting May 2-3, 1959 in Atlantic City.

* * *

Dr. William S. Kroger, associate professor of obstetrics and gynecology at the Chicago Medical School, was elected president of the Academy of Psychosomatic Medicine at its recent annual meeting in New York City. Other officers are Dr. Maury D. Sanger of Brooklyn, vice-president; Dr. Bertram B. Moss of Chicago, secretary; Dr. Zale A. Yanof of Toledo, treasurer, and Dr. M. Murray Peshkin of New York City, historian.

Dr. Wilfred Dorfman of Brooklyn, president-elect, will succeed Dr. Kroger at the 6th

annual meeting of the academy next October in Cleveland.

* * *

PUBLICATIONS

More than 125 new drugs have been tested or are currently under study in New York's mental hospitals. A number of the drugs already have been established as useful for special types of mental illness, according to Dr. Paul H. Hoch, mental hygiene commissioner.

New York was the first state to undertake a large-scale program with two of the drugs—chlorpromazine and reserpine—in 1955, after a full year of tests. Today 40,000 patients (45% of the hospital population) are receiving drugs as part of their treatment.

Under Dr. Hoch's direction over 300 full-time researchers are using, besides drugs, a wide variety of modern techniques in the study of psychiatric problems. Included are the electronic brain, electron microscope, radioactive isotopes, delicate types of chemistry and electronics, and brain wave devices permitting measurement within millionths of a volt or gram.

New York has also been hailed throughout the country for trying new techniques of hospital organization and operation, such as the day hospital and the unlocked ward.

These and other aspects of the state's total approach to public mental health are graphically described in a publication, *Design for Mental Health*, released recently by Dr. Hoch's office. Single copies may be obtained without charge from the Office of Mental Health Education and Information, New York State Department of Mental Hygiene, 217 Lark St., Albany.

* * *

A tentative list of general hospitals accepting psychiatric patients for treatment, diag-

nosis or emergencies was circulated in October by the Joint Information Service co-sponsored by the National Association for Mental Health and the American Psychiatric Association.

To complete the list, those receiving a copy were asked to notify the JIS of additional hospitals that should be included. The list covers the U. S., its territories and Canada.

* * *

Six hundred articles on mental hospitals are listed in a new pamphlet compiled by the American Psychiatric Association. They are categorized under administration, design, day hospitals, general hospital units, outpatient clinics, children's units, receiving hospitals, rehabilitation services, social structure, ancillary therapies, medical records, nursing services, follow-up care and equipment.

The pamphlet, titled *Selected Reading Lists on Mental Hospitals (1948-1958)*, also lists the names and addresses of pertinent journals, including *Mental Hygiene*.

* * *

There's a manpower shortage in U. S. institutions for mental defectives, just as in mental hospitals, according to a report of the Joint Information Service co-sponsored by the National Association for Mental Health and the American Psychiatric Association.

The shortage, disclosed in an opinion survey conducted by APA's Central Inspection Board, shows up in eight categories of personnel. Officials of 84 hospitals and schools estimated they had only 55.9% of the doctors they would like to have, 48.9% of the nurses, 72% of the attendants, 47.4% of the psychologists, 40.7% of the social workers, 53.1% of the teachers, 21.2% of the occupational therapists and 29.5% of the recreational therapists.

The 84 hospitals and schools care for 94% of all mental defectives in public institutions. The opinion survey was the first step in establishing personnel standards for these institutions.

Findings of the survey are analyzed in Fact Sheet No. 7, published in September by the Joint Information Service and available from NAMH.

* * *

The first two in a series of 10 monographs sponsored by the Joint Commission on Mental Illness and Health are off the press.

They are *Current Concepts of Positive Mental Health* by Marie Jahoda¹ and *Economics of Mental Illness* by Rashi Fein.²

Eight more monographs are to be published during the coming year. A final report of findings and recommendations for a national mental health program will be made by the commission in the latter part of 1959.

The third monograph, to be published this winter, will be a study of mental health manpower. The fourth, scheduled for publication in the late winter or spring, will report on a nation-wide sampling survey of mental health.

The Joint Commission was organized under provisions of the Mental Health Study Act of 1955 and charged with the responsibility of making a 3-year national health study. The commission is made up of 37 voluntary and government agencies interested in mental health.

Dr. Jahoda found that people define mental health in many different ways. In the present state of knowledge, she believes each is entitled to his own definition. As evidence, her published report contains a dissenting opinion from a member of the

¹ New York, Basic Books, \$2.75, 160 pages.

² New York, Basic Books, \$3.00, 184 pages.

commission, Dr. Walter E. Barton, Boston psychiatrist.

Dr. Jahoda rejects either "absence of mental disease" or "normality" as good definitions of mental health. She doesn't like the first because "mental illness" itself has not been acceptably defined, particularly in its milder forms, in certain character disorders and in anti-social and criminal personalities.

Normality, she says, tends to become synonymous with the average, or what the majority of people feel, think and do. But they do much that one would hesitate to call healthy, she points out. She notes that standards of normal behavior vary with the time, place, culture and expectations of the group.

In searching for a definition of mental health, Dr. Jahoda found that scientists who have done research on this question have used six different yardsticks in measuring mental health:

1. Attitudes of the individual toward himself (self-perception). The emphasis is on "being oneself," and on seeing oneself as he is, not confusing ideal self and real self.

2. Achievement of one's potentiality for growth and development (self-actualization). Mental health is seen as the product of striving for self-realization—of becoming what one can be.

3. A pulling or tying together of all functions in the individual's personality (integration). The integrated personality has an internal psychic balance and unifying philosophy that give life purpose and meaning, and hence considerable tolerance for stress, anxiety or frustration and a capacity of resilience or ability to recover from setbacks.

4. Individual's degree of independence from social influences (autonomy). The autonomous individual accepts parts of his environment and rejects others; he is able

to "be himself" and yet be part of "something greater than himself."

5. How the individual sees the world around him (perception of reality). Such perception is healthy when the individual sees what is really there, or what he sees is not distorted by some inner need, or he has a sense of how others feel.

6. Ability to take life as it comes and master it (environmental mastery). Here, success becomes the goal and adaptation a means to success. Ability to love, work, play, solve problems and meet the requirements of any situation is necessary.

Each yardstick presents one complication or another in applying it to everybody, Dr. Jahoda indicates.

She observes that the one value in American culture compatible with most approaches to a definition of good mental health appears to be this: An individual should be able to stand on his own two feet without making undue demands or impositions on others. This might be regarded as a minimum definition, although Dr. Jahoda hastens to point out:

"In the present state of our knowledge, perhaps it would be best to conclude that there are various types of mental health and that multiple standards can be applied to each. The genius and the moron and the average man may each have his own type of mental health."

Dr. Barton, expressing a typical medical viewpoint, dissents from rejection of the absence of illness as a criterion of mental health:

"Conceptually, it is difficult to see how a national program to reduce mental illness and increase mental health can be operated on any other base line than a straight one. In this continuum, illness is the point of departure and health is the goal. We work away from one and toward the other.

"If we had solved, or even partially

solved, the problems of preventing or treating major and minor mental illness, we could then justifiably concern ourselves with the issue of superlative mental health, or the degrees of goodness in good mental health. Unfortunately, we still have far to go in reducing illness. This is a practical concern, rather than a theoretical one."

* * *

The cost of mental illness in the United States probably exceeds \$3,000,000,000 a year, Dr. Fein found.

He examined both direct and indirect costs. Direct costs included public and private expenditures for the care of the mentally ill and for mental health research. Indirect costs were hidden in the annual loss of production and income and in the loss of future earnings.

Dr. Fein estimates the direct costs at more than \$1,700,000,000 a year. The largest item is the care of patients in federal, state and county mental hospitals.

The probable minimum costs of private psychiatric care is estimated at \$100,000,000. It does not include the cost of care of patients with mental illness by general practitioners and specialists in internal medicine, believed to be between \$241,000,000 and \$1,205,000,000.

Dr. Fein estimates that patients in state and county mental hospitals and psychopathic hospitals annually lose 325,000 labor-force years with a dollar value of more than \$728,000,000. He computed, therefore, that the total direct and indirect costs each year exceeded \$2,400,000,000. But he noted that this total did not include private medical costs other than full-time private psychiatric care.

Judging from the discussion of low and high estimates of the cost of private medical care for the mentally ill, allowing for the fragmentary nature of the information

in this and in other directions, and fully realizing that certain omitted categories of costs cannot be estimated, the total direct and indirect costs of mental illness in the United States may be safely assumed to be in excess of \$3,000,000,000 a year.

Dr. Fein warns against an economic approach that holds large direct costs as undesirable and something to be eliminated, pointing out that the primary purpose of non-profit institutions is not to make a profit but to provide service and that, even in profit-making enterprises, costs need be minimized only to what is consistent with a given level of production.

In determining what should and can be spent for mental illness out of existing resources, he recommends the following economic reasoning as appropriate:

The only meaningful concept is that total costs comprise both direct and indirect costs. The nation bears the cost of mental illness whether it finances the direct costs or not. Economic considerations do not necessarily concern themselves with human or ethical values, but it is possible that increases in direct costs may reduce total costs. Measures reducing indirect costs are welcome, even though they may add to direct costs.

Dr. Fein refrains from attempting to tell legislatures where to find the money to meet the needs of mental illness as well as all other public needs, but suggests that an economy can afford to spend whatever it desires to spend. All that is necessary to spend more on one thing, he says, is to spend less on something else. What will be spent depends on the tax rate and the value system we embrace. The public and its leaders must make the choice.

* * *

A new program aid for the use of mental health associations was distributed during a staff institute sponsored by the National As-

sociation for Mental Health November 16-18 in Kansas City. It is designed to guide the expansion of vocational rehabilitation services for former mental patients.

A rounded vocational rehabilitation program, according to the new publication, offers the patient counseling or vocational guidance, vocational training, an opportunity to develop sound work habits (in a sheltered workshop, if necessary), and aid in finding a job with an understanding employer.

The booklet was drafted by Morris Klapper, assistant executive director of NAMH. In it, he sets out the basic principles to be followed in organizing a sound vocational rehabilitation program for psychiatric patients. Sixteen reviewers (including several state and local mental health association executive directors) to whom the first draft was submitted commented favorably on both the material and the way it was presented, calling them "realistic," "sensible" and "very useful."

Mr. Klapper has proceeded on two assumptions: that rehabilitation starts on the day the patient enters a mental hospital and that the day of his discharge may be the most difficult one of all as he gropes his way back to health. Is he ready for normal community life, and is the community ready for him?

"This is the challenge to the mental health association," Mr. Klapper points out. "It is our job to stimulate both a climate and a pattern of community service which helps mental patients come back—ready to lead satisfying, self-sustaining lives—to communities ready to receive them."

In creating a favorable atmosphere for returning mental patients, Mr. Klapper notes, mental health associations will work in close harmony with state mental hospital administrators, state legislators and

state mental hygiene and vocational rehabilitation officials. Among other things, the associations can make a major contribution by helping these state agencies take full advantage of the variety of federal grants available for vocational programs.

It is also up to mental health associations to encourage community rehabilitation centers to extend their services to the mentally ill just as these centers help the blind, the crippled and the cardiac, Mr. Klapper writes.

Other avenues of service open to mental health associations are home-finding, continuous educational programs designed to break down industry's resistance to the hiring of ex-mental patients, and the recruitment of volunteers trained in occupational therapy, manual arts and specific aspects of the job market.

The booklet includes a short list of references and recommended readings, the names of the 12 advisers to the U. S. Office of Vocational Rehabilitation, and a brief description of 10 OVR-financed demonstration and research projects in the mental health field. Two of the 10 are going on under the auspices of the Massachusetts Association for Mental Health.

* * *

A new 20-page document, first compilation of its kind, supplies information useful to all who are engaged in or planning child guidance clinic operations.

It is Fact Sheet No. 6 issued by the Joint Information Service of the American Psychiatric Association and the National Association for Mental Health. The issue, entitled "Variations in Organizational Practices Among Child Guidance Clinics, 1955," summarizes reports from 95 member clinics of the American Association of Psychiatric Clinics for Children.

The study of selected clinics in various parts of the country shows such a wide range of variation as to indicate there is no "average" clinic for children.

"No attempt is made," it says, "to do anything more than give some indication as to the range of organization and practices possible in clinics which emphasize the team approach to the treatment—by well qualified professionals—of psychiatric problems in children."

The summary covers the financing of such clinics, the services they offer, the requirements for clinical services, professional and clerical salaries, fees charged and data on case loads.

* * *

The proceedings of the 3rd Hospital Recreation Institute, co-sponsored last January by New York University's school of education and the National Recreation Association, have been published under the title of *Recreation for the Ill and Handicapped Homebound*.

The proceedings describe existing recreation services for the ill and handicapped who are homebound, and discuss ways of developing community resources for this group, of recruiting, screening, training and placing volunteers, and of using recreation to teach the physically or mentally ill.

Copies are available from the National Recreation Association, 8 W. 8th St., New York 11, for \$1.25 each.

* * *

The September 15 bulletin of the Social Legislation Information Service briefly describes federal government activities on behalf of the aging as carried on by the Department of Labor, Housing and Home Finance Agency, Small Business Administration, Department of Agriculture, Department of Commerce, Treasury Department,

Veterans' Administration, Railroad Retirement Board and Civil Service Commission.

Programs of the Department of Health, Education and Welfare for older people were summarized in an earlier issue (No. 5).

* * *

When skilled psychiatric aides have the qualifications for becoming professional nurses, they deserve all the help they can get.

Efforts of two New Jersey institutions to help aides get the professional education they need are described in an article titled "A Cooperative Plan for Bettering Care to the Mentally Ill" in the September 1958 issue of *Nursing Outlook*. The article was written by Miss Mildred S. Schmidt, consultant on the junior college nursing curriculum for the National League for Nursing, and Dr. J. Berkeley Gordon, chief executive officer and medical director at the New Jersey State Hospital at Marlboro.

Miss Schmidt was formerly director of the nursing school and nursing service at Monmouth Memorial Hospital School of Nursing in Long Branch, N. J., the school that accepts selected aides and prepares them for professional nursing.

Other articles in the same issue describe Ohio's residency program in psychiatric nursing and the place of mental health in the visiting nurse program.

In the October issue of the same magazine Dr. Richard Fleming, a psychiatrist, and Miss Winifred McLanahan, a mental health nurse consultant, tell how the staff nurses and supervisors of the Allegheny County (Pa.) Visiting Nurse Association went about adding mental health services to their repertoire. In the November issue the same authors present a number of cases showing how they were able to help staff nurses and supervisors provide more and

better services for emotionally disturbed or mentally ill patients and their families.

REHABILITATION

Although Ohio's mental hospitals are now discharging more patients than they are admitting, many patients, unable to make their way in a hostile community, have to return to the hospital. To correct this situation, the Cleveland Mental Health Association has put 20 business men, vocational counselors, social workers and ministers to work studying methods of reducing readmission rates.

The committee learned that mental hospitals want help in finding new jobs for about-to-be-discharged patients, since less than half return to their former jobs. The committee also learned that being able to find and keep a job is one of the crucial tests of a patient's success in returning to the community. Among the factors affecting his getting steady work are the hiring practices and attitudes of employers, the patient's work record and ability to fit into a group, the support he receives from his family and counselors in the crucial days of job-hunting and beginning new work, and any special problems such as his need for time off for visits to the clinic.

Cleveland personnel executives with whom the committee has discussed the overall problem have recommended the publication of a pamphlet for prospective employers. It should stress, they suggested, the steadying effect of the tranquilizers,

experiences of employers in hiring former mental patients, and information by experts on what they can expect from patients they employ.

The committee believes each discharged patient should have the benefit of 5 aids in applying for a job:

- Group discussion before his discharge to help him build confidence and overcome apprehension.
- Discussions before his job interviews with someone outside the hospital, such as an employment counselor or social worker.
- An accurate record of his training and experience.
- First placement in a company with fewer than 50 employees, preferably one managed by the owner.
- Help to the employer in waiting out initial maladjustments that may arise.

"We see a serious need for further systematic study of the tranquilizing drugs and their part in the rehabilitation of mental patients," the committee writes. "Patients who formerly would have been hospitalized can now be kept going by the drugs outside institutions, but their grasp on reality may remain fragile. This poses problems for the community, both of accepting responsibility for the patients and of educating the general public about this situation."

NATIONAL ASSOCIATION FOR MENTAL HEALTH, INC.

Voluntary Promotional Agency of the Mental Hygiene Movement founded by Clifford W. Beers

OBJECTIVES: The National Association for Mental Health is a coordinated citizens organization working toward the improved care and treatment of the mentally ill and handicapped; for improved methods and services in research, prevention, detection, diagnosis and treatment of mental illnesses and handicaps; and for the promotion of mental health.

Judge Luther Alverson
President

Brandon Barringer
Secretary

Herbert J. Osborne
Treasurer

BOARD OF DIRECTORS

Judge Luther Alverson
Chairman

Reginald G. Coombe
1st Vice-Chairman

Bernard G. Goldstein
2nd Vice-Chairman

James S. Adams
William W. Allis
Hon. Luther Alverson
Dr. Kenneth E. Appel
Dr. Walter H. Baer
Bentley Barnabas
Brandon Barringer
Dr. Leo H. Bartemeier
Carlyle Barton, Jr.
S. Heagan Bayles
C. Neale Bogner
Charles A. Boynton, Jr.
Mrs. Edward W. Briggs, Jr.
Judge David Brofman
G. Werber Bryan
Dr. Rives Chalmers
Dr. Thaddeus B. Clark
Mrs. William Clarke
Thomas M. Comegys, Jr.
Reginald G. Coombe
Mrs. John S. Cowan
David C. Crockett
Jesse L. Dickinson
P. H. Dougherty
Robert D. Drew
Mrs. A. Felix duPont, Jr.

Mrs. Fred J. Early, Jr.
Dr. Harold W. Elley
Frank F. Elliott
Irving Enna
R. B. Everett
Dr. Francis J. Gerty
John C. Godbold
Bernard G. Goldstein
William Grant, Jr.
George E. Gullen, Jr.
Mrs. M. E. Harris, Jr.
Dr. Don W. Herrold
Dr. Elmer Hess
Clarkson Hill
Miss Sibyl M. Howe
Mrs. Henry Ittleson
Mrs. Mary I. Jeffries
Michael Johnson
Paul Johnston
Mrs. Burton Joseph
Stuart E. Judd
Dr. Marion E. Kenworthy
Dr. Irving Lazar
Mrs. Fred Lazarus, Jr.
Dr. Paul V. Lemkau

Gifford M. Mast
Hon. Augustus G. Means
Edwin R. Mohrmann
Ralph H. Ojemann
James R. Oppenheimer
Herbert J. Osborne
Hugh G. Payne, Sr.
Frank E. Proctor
Earl Raab
Mrs. Ernest R. Rector
Hon. Lawrence Renfroe
Mrs. Joy H. Roth
Julius F. Rothman
F. Barry Ryan, Jr.
Dr. William T. Sanger
G. Howland Shaw
Frederick G. Singer
Daniel C. Smith
Mrs. A. G. Spindler
Dr. Harvey J. Tompkins
Mrs. E. Sheldon Watson
Mrs. Fred Weser
Dr. John C. Whitehorn
Mrs. John Miller Williams
Victor P. Wilson
Joseph A. Wyant

Richard P. Swigart
Executive Director

George S. Stevenson, M.D.
Consultant

